

EXHIBIT 62

DEPOSIT

Enter Your Account Number 001

1	1	0	8	0	0	7	0	5	3
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☒ Checking
 ☐ Passbook Savings
 ☐ Statement Savings
 ☒ CD

Sign Diagnostic & Clinical

Address Pension Fund

Date 2/27/03

Independence
 Community Bank

1071

DEPOSIT

Cash		
Check	1850.00	00
Total		
Less Cash Returned		
Deposit	1850.00	00

DEPOSITS MAY NOT BE AVAILABLE FOR IMMEDIATE WITHDRAWAL. CHECKS AND OTHER ITEMS RECEIVED FOR DEPOSIT ARE SUBJECT TO THE TERMS AND CONDITIONS OF I.C.B.'S FUNDS AVAILABILITY

ENTER TOTAL ON THE FRONT OF THIS TICKET

18	17	16	15	14	13	12	11	10	9	8	7	6	5	4	3	2	1
TOTAL																	
0015 02/27/2003 110/03092 108007053 001																	
Cash \$1,850,000.00 AVAILABLE \$1,850,000.00 DEPOSIT \$7,945,194.68																	
BALANCE \$7,945,194.68																	

PLEASE ENDORSE ALL CHECKS CHECKS MUST SIGNIFY DOLLARS CENTS

INDEPENDENCE COMMUNITY BANK

PENDING 800-631-0980

PLAINTIFF'S EXHIBIT

CRISCITO 25

12-11-09

EXHIBIT 63



32 Chelsea Dr, Livingston, NJ 07039

© 2010 Google

Google

40°47'21.01" N 74°17'40.37" W elev 488 ft

Eye alt 633 ft

EXHIBIT 64

DEMPSEY, DEMPSEY & SHEEHAN

Deed

14

1024716
This Deed is made on **MAY 03 2004**
BETWEEN
SCOTT SPECTOR and PATRICIA SPECTOR, husband and wife

whose post office address is
32 Chelsea Drive, Livingston, NJ

referred to as the Grantor,
AND
MARIO CRISCITO and DONNA CRISCITO, husband and wife

whose post office address is
about to be 32 Chelsea Drive, Livingston, NJ

referred to as the Grantee.
The words "Grantor" and "Grantee" shall mean all Grantors and all Grantees listed above.

1. **Transfer of Ownership.** The Grantor grants and conveys (transfers ownership of) the property (called the "Property") described below to the Grantee. This transfer is made for the sum of
TWO MILLION FIVE HUNDRED THOUSAND DOLLARS (\$2,500,000)
The Grantor acknowledges receipt of this money.

2. **Tax Map Reference.** (N.J.S.A. 48:15-1.1) Municipality of Livingston
Block No. 2400 Lot No. 87 Qualifier No. Account No.
☐ No property tax identification number is available on the date of this Deed. (Check Box if Applicable.)

3. **Property.** The Property consists of the land and all the buildings and structures on the land in
the Township of Livingston
County of Essex and State of New Jersey. The legal description is:

☒ Please see attached Legal Description annexed hereto and made a part hereof. (Check Box if Applicable.)
Being the same premises conveyed to Scott Spector and Patricia Spector, husband and wife, by Deed from Bel Air Associates, Inc. dated November 2, 1994, and recorded November 4, 1994, in the Essex County Register's Office in Deed Book 5339 page 164.



Instr# 1024716 Carol A. Graves
Recorded/Filed KPJ 1 Essex County Register
05/20/2004 10:16:58 BK 6069 PG 758 PP 5 of 5

Consideration:	2500000.00	R
County:	2500.00	
State:	6250.00	
N.P.S.E.:	3528.00	
Realty Tax:	18878.00	
Fees:	80.00	

Prepared by: (print signer's name below signature)

Robert W. Dempsey, Esq.

(For Recorder's Use Only)

Bill of Sale

This Bill of Sale is made on May 3, 2004

BY

Scott Spector
whose address is
32 Chelsea Drive
Livingston, New Jersey 07039

Patricia Spector

TO

Marlo Criscito
whose address is
about to be 32 Chelsea Drive
Livingston, New Jersey 07039

referred to as the Seller,

Donna Criscito

referred to as the Buyer.

The words "Buyer" and "Seller" include all Buyers and all Sellers listed above.

1. **Transfer of Ownership.** The Seller transfers ownership of the Property described below to the Buyer. The Seller has been paid \$ 1,000,000.00 and other good and valuable consideration for making this transfer.

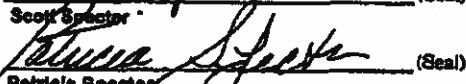
2. **Property.** The following Property is sold to the Buyer (referred to hereinafter as the "Property"):
All personal property remaining in the real property located 32 Chelsea Drive, Livingston, New Jersey, including, but not limited to, all furnishings, mirrors, rugs, carpets, draperies, lamps, some fixtures, pool furniture and all other items remaining at the above referenced property. The Sellers represent that there are no liens or other sums due and owing to any other parties with respect to said personal property.

3. **Promises by Seller.** The Seller promises that no one else has any legal rights in the Property. If anyone claims to have legal rights in the Property, the Seller will defend the Buyer against the claim and will pay all costs, attorney fees and damages.

4. **Signatures.** The Seller agrees to the terms of this Bill of Sale. If this Bill of Sale is made by a corporation, its proper corporate officers sign and its corporate seal is affixed hereto.

Witnessed or Attested By:


Robert W. Dempsey, Esq.

 (Seal)
Scott Spector
 (Seal)
Patricia Spector

AFFIDAVIT OF OWNERSHIP

STATE OF NEW JERSEY,
COUNTY OF UNION

SS:


Scott Spector

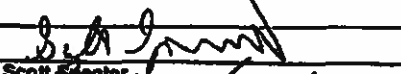
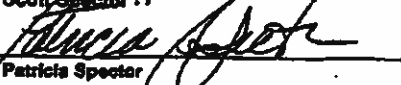
Patricia Spector

say(s) under oath:

The Seller is the owner of the Property described in this Bill of Sale. If the Seller is an individual, the Seller is at least 18 years old. The Seller is in sole possession of this Property. No other persons have any legal rights or security interest in this Property. There are no pending lawsuits or judgments against the Seller or other legal obligations which may be enforced against this Property. No bankruptcy or insolvency proceedings have been started by or against the Seller.

Signed and sworn to before me on 05/03/04


Robert W. Dempsey, A NJ Attorney
Prepared by:

 Scott Spector
 Patricia Spector

Print signer's name below signature

1362 - Bill of Sale -
Ind. or Corp.
Rev 1/01 P 6/01

Inst# 1024716 BK# 6069 PG# 759

by ALL-STATE LEGAL®
Division of ALL-STATE International, Inc.
www.eslegal.com 800.222.0610 Page 1

Ann 5

STATE OF NEW JERSEY, COUNTY OF UNION

SS:

I CERTIFY that on May 3, 2004

Scott Spector

Patricia Spector

personally came before me and acknowledged under oath, to my satisfaction, that this person (or if more than one, each person):

- a. is named in and personally signed this document; and
- b. signed, sealed and delivered this document as his or her act and deed.


Robert W. Dempsey

An Attorney at Law of the State of NJ

Print name and title below signature

STATE OF NEW JERSEY, COUNTY OF

SS:

I CERTIFY that on

personally came before me, and this person acknowledged under oath, to

my satisfaction that:

- a. this person is the _____ of
the corporation named in this document;
- b. this person is the attesting witness to the signing of this document by the proper corporate officer who is
the _____ of the corporation;
- c. this document was signed and delivered by the corporation as its voluntary act duly authorized by a proper
resolution of its Board of Directors;
- d. this person knows the proper seal of the corporation which was affixed to this document; and
- e. this person signed this proof to attest to the truth of these facts.

Signed and sworn to before me on _____

Print names of attesting witness below signature

Bill of Sale

Scott Spector
Patricia Spector

Seller

TO

Mario Crisollo
Donna Crisollo

Buyer

DATED: _____

RECORD AND RETURN TO:

Thomas E. Cohn, Esq.
WOLF BLOCK BRACH EICHLER
101 Eisenhower Parkway
Roseland, NJ 07068

HERITAGE ABSTRACT COMPANY

**SCHEDULE A-4
LEGAL DESCRIPTION**

Commitment No. H-79819

All that tract or parcel of land and premises, situate, lying and being in the Township of Livingston in the County of Essex and State of New Jersey, more particularly described as follows:

Being known and designated as Lot 63 in Block 233D as shown on a certain map entitled, "Final Plat, Bel-Air - Phase Two, Township of Livingston, Essex County, NJ", which map was filed in the Essex County Register's Office on October 16, 1991 as Map No. 3809.

BEING further described as follows:

BEGINNING at a point in the westerly side of Chelsea Drive, said point being where the same is intersected by the dividing line between Lots 62 and 63 in Block 223D as shown on the map above referred and from thence; running

- (1) Along said dividing line, South 83 degrees 34 minutes 40 seconds West 268.28 feet to the rear line of Lot 63; thence
- (2) Along the same, North 28 degrees 16 minutes 04 seconds West 220.56 feet; thence
- (3) South 70 degrees 42 minutes 29 seconds East 68.12 feet; thence
- (4) South 86 degrees 37 minutes 16 seconds East 304.00 feet to the westerly side of Chelsea Drive; thence
- (5) Along the same in a general southerly direction on a curve to the left having a radius of 725.00 feet an arc length of 124.02 feet to the point and place of **BEGINNING**.

NOTE FOR INFORMATION ONLY:

Being commonly known as Tax Lot 87 Block 2400 (32 Chelsea Drive) on the Tax Map of the Township of Livingston, Essex County, New Jersey.

Heritage Abstract Company
Phone: 973-540-1345 Fax: 973-292-1799
As Issuing Agent For
NEW JERSEY TITLE INSURANCE COMPANY

Inst# 1024716 BK# 6069 PG# 761

DEMPSEY, DEMPSEY & SHEEMAN

The street address of the Property is:
32 Chelsea Drive, Livingston, New Jersey

4. Promises by Grantor. The Grantor promises that the Grantor has done no act to encumber the Property. This promise is called a "covenant as to grantor's acts" (N.J.S.A. 46:4-6). This promise means that the Grantor has not allowed anyone else to obtain any legal rights which affect the Property (such as by making a mortgage or allowing a judgment to be entered against the Grantor).

5. Signatures. The Grantor signs this Deed as of the date at the top of the first page. (Print name below each signature.)

Witnessed By:



Scott Spector (Seal)



Robert W. Dempsey



Patricia Spector (Seal)

(Seal)

STATE OF NEW JERSEY, COUNTY OF UNION
I CERTIFY that on MAY 03 2004

SS.

Scott Spector and Patricia Spector, husband and wife

personally came before me and stated to my satisfaction that this person (or if more than one, each person):

(a) was the maker of this Deed;

(b) executed this Deed as his or her own act; and,

(c) made this Deed for \$ 2,500,000

as the full and actual consideration paid or to be paid for the
transfer of title. (Such consideration is defined in N.J.S.A. 46:15-5.)

RECORD AND RETURN TO:
Thomas E. Cohn, Esq.

Wolf Block Brach Eichler
101 Eisenhower Parkway
Roseland, NJ 07068



(Print name and title below signature)
Robert W. Dempsey
Attorney at Law of New Jersey

EXHIBIT 65

610 Corporate Drive, Building 6
Reading, PA 19605
Phone: 484-248-1210
Fax: 484-248-1120 or
484-248-1121



Sovereign



Santander

Fax

To: Stephen M. Charne, Esquire

From: Mandy Noll

Fax: 973-822-1188

Date: 8-27-2009

Phone:

Pages: 45 (Including cover sheet)

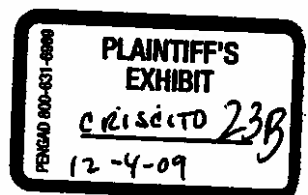
Re: Diagnostic & Clinical Cardiology PA

CC:

☐ Urgent ☒ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

•Comments:

Fax #2 of 2




DEPOSIT

Enter Your Account Number


1	1	0	8	0	0	7	0	5	3	001
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☐ Checking
 ☐ Passbook Savings
 ☐ Statement Savings
 ☐ CD

Sign 

Address _____

Date _____



Independence

Independence Community Bank
A Bank & Trust

1071

DEPOSIT

Cash	-	-
Check	95,975	-
Total	95,975	-
Less Cash Returned		
Deposit		

DEPOSITS MAY NOT BE AVAILABLE FOR IMMEDIATE WITHDRAWAL. CHECKS AND OTHER ITEMS RECEIVED FOR DEPOSIT ARE SUBJECT TO THE TERMS AND CONDITIONS OF I.C.B.'S FUNDS AVAILABILITY.

ENTER TOTAL ON THE FRONT OF THIS TICKET

										DOLLARS		CENTS
0060	03/18/2005	110/05663	ST	Cash	\$95,975.00	1108007053 001	\$95,975.00	DEPOSIT	\$4,282,972.14	\$4,282,972.14		
TOTAL						AVAILABLE BALANCE						

PLEASE EXAMINE ALL CHECKS
CHECKS LIST SEPARATELY

INDEPENDENCE COMMUNITY BANK

DEPOSITS MAY NOT BE AVAILABLE FOR IMMEDIATE
WITHDRAWAL CHECKS AND OTHER ITEMS RECEIVED
FOR DEPOSIT ARE SUBJECT TO THE TERMS AND
CONDITIONS OF I.G.B.'S FUNDS AVAILABILITY

DOLLARS		CENTS
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16		
17		
18		
TOTAL		

0007
05/25/2005

110/03092
TOR

110601727
\$50,000.00

DEPOSIT

CK

INDEPENDENCE COMMUNITY BANK

PLEASE ENDORSE ALL CHECKS
CHECKS MUST SINGLY

ENTER TOTAL ON THE FRONT OF THIS TICKET

WITHDRAWAL FROM
INDEPENDENCE
COMMUNITY BANKTransfer to
1106011727

FOR:

- ☐ RETURNED CHECK
☐ LOAN DELINQUENCY
☐ DIVIDEND REMITTANCE
☐ PRINCIPAL PAYOUT
☐ PREM. PAYT.-S.B.L.I.

AMOUNT \$ 50,000 00

Charge to Account No. 1108007053001

Depositor's
NameSupervisor's
Approval

1073 REV. 8/98

Diagnostic Clinical Cardiology
*[Signature]*0007
03/25/2005

110/03092

TOR ST
Trans \$50,000.001108007053 001
\$50,000.00

WITH

INDEPENDENCE C

DEPOSITS MAY NOT BE AVAILABLE FOR IMMEDIATE
WITHDRAWAL. CHECKS AND OTHER ITEMS RECEIVED
FOR DEPOSIT ARE SUBJECT TO THE TERMS AND
CONDITIONS OF I.C.B.'S FUNDS AVAILABILITY

DOLLARS		CENTS
1	CK	
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10	110601727	
11	\$150,000.00	
12		
13		
14		
15	110/05246	
16	TOR	
17		
18		
19	0029	
20	04/08/2005	
21	TOTAL	

INDEPENDENCE COMMUNITY BANK

DOLLARS	CENTS
0029	
04/08/2005	
FOR	
NB	
1108007053 001	
\$500,000.00	
DEPOSIT	
TOTAL	

WITHDRAWAL

Enter Your Account Number
5700345041

Amt \$ 650,000.

☒ Checking ☐ Passbook ☐ Statement ☐ CD
Savings Savings

Pay the amount of
Six hundred fifty thousand 00/100

Sign [Signature] Date _____

Address Livingston

Independence TNF 1106011727
Community Bank 1108007053001

WITHDRAWAL

INDEPENDENCE COMMUNITY BANK

WITHDRAWAL CX

570034504
\$650,000.00

Trans \$650,000.00

110/05248

0029
04/08/2005

DOLLARS	CENTS
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TOTAL	

ENTER TOTAL ON THE FRONT OF THIS TICKET

0006
 05/02/2005

110/05463
 TOR

570034504
 \$100,000.00

DEPOSIT

CX

INDEPENDENCE COMMUNITY BANK

WITHDRAWAL FROM
INDEPENDENCE
COMMUNITY BANK

To: 570034504

FOR:

- ☐ RETURNED CHECK
☐ LOAN DELINQUENCY
☐ DIVIDEND REMITTANCE
☐ PRINCIPAL PAYOUT
☐ PREM. PAYT.-S.B.L.I.

AMOUNT \$100,000 -

5-2-2005

Charge to Account No. 1108007053001

Depositor's
Name Diagnostic & Clinical

Supervisor's
Approval [Signature]
1073 REV. 8-99

0006
05/02/2005

110/05663

TOR ST
Trans \$100,000.00

1108007053 001
\$100,000.00

WITHI

INDEPENDENCE (

DEPOSITS MAY NOT BE AVAILABLE FOR IMMEDIATE
WITHDRAWAL. CHECKS AND OTHER ITEMS RECEIVED
FOR DEPOSIT ARE SUBJECT TO THE TERMS AND
CONDITIONS OF I.C.B.'S FUNDS AVAILABILITY

COLLARS		CENTS
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18		
TOTAL		

0039
05/24/2005

110/05863

1106011727

INDEPENDENCE COMMUNITY BANK

WITHDRAWAL FROM
INDEPENDENCE
COMMUNITY BANK

To: 1106011727

FOR:

- ☐ RETURNED CHECK
☐ LOAN DELINQUENCY
☐ DIVIDEND REMITTANCE
☐ PRINCIPAL PAYOUT
☐ PREM. PAYT.-S.B.L.I.

AMOUNT \$200,000.00

5/24/05

Charge to Account No. 1108007053001

Depositor's Name Diagnostic & Clinical Care

Supervisor's Approval [Signature]

1073 REV. 6/99

0039
05/24/2005

110/05663

TOR ST
Trans \$200,000.00

1108007053 001
\$200,000.00

WITH

INDEPENDENCE

DEPOSITS MAY NOT BE AVAILABLE FOR IMMEDIATE
WITHDRAWAL. CHECKS AND OTHER ITEMS RECEIVED
FOR DEPOSIT ARE SUBJECT TO THE TERMS AND
CONDITIONS OF I.C.B.'S FUNDS AVAILABILITY

DOLLARS		CENTS
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18		
TOTAL		

ENTER TOTAL ON THE FRONT OF THIS TICKET

INDEPENDENCE - HUMANITY - RISK

WITHDRAWAL FROM
INDEPENDENCE
COMMUNITY BANK

To: 570034504

FOR:

- ☐ RETURNED CHECK
☐ LOAN DELINQUENCY
☐ DIVIDEND REMITTANCE
☐ PRINCIPAL PAYOUT
☐ PREM. PAYT.-S.B.L.I.

AMOUNT \$100,000

6/10/05

Charge to Account No. 1108007053001

Depositor's
Name

Diagnostic & Clinical Card.

Supervisor's
Approval

M. J. P. C.

1073 REV. 6/99

INDEPENDENCE C

Trans \$100,000.00

10R ST

1108007053 001

WITH

110/05242

06/10/2005

DEPOSIT

Enter Your Account Number


1	1	0	6	0	1	1	7	2	7
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☐ Checking ☐ Passbook Savings ☐ Statement Savings ☐ CD

Sign *[Signature]*

Address _____

Date 7/15/05

 **Independence**
Community Bank

1071

Cash		
Check	60,000	—
Total		
Less Cash Returned		
Deposit	100,000	—

DEPOSITS MAY NOT BE AVAILABLE FOR IMMEDIATE
WITHDRAWAL, CHECKS AND OTHER ITEMS RECEIVED
FOR DEPOSIT ARE SUBJECT TO THE TERMS AND
CONDITIONS OF I.C.B.'S FUNDS AVAILABILITY.

	DOLLARS	CENTS
1	0082	
2	07/15/2005	
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5	TDR	
6	110/05706	
7		
8		
9		
10	1106011727	
11	\$100,000.00	
12		
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14		
15		
16	DEPOSIT	
17		
18	CK	
19		
20	TOTAL	

INDEPENDENCE COMMUNITY BANK

ENTER TOTAL ON THE FRONT OF THIS TICKET

PLEASE ENCOURSE ALL CHECKS
CHECKS MUST SINGLY

WITHDRAWAL FROM
INDEPENDENCE
COMMUNITY BANK

TUT-1106011727

FOR:

- ☐ RETURNED CHECK
☐ LOAN DELINQUENCY
☐ DIVIDEND REMITTANCE
☐ PRINCIPAL PAYOUT
☐ PREM. PAYT.-S.B.L.I.

AMOUNT \$10,000 -

Charge to Account No. 1108007053001

Depositor's
Name

Supervisor's
Approval

1073 REV. 6/99

INDEPENDENCE

11/05/2006 108 51 Trans \$100,000.00
1108907053 001 \$100,000.00
07/15/2005 206

DEPOSITS MAY NOT BE AVAILABLE FOR IMMEDIATE
WITHDRAWAL. CHECKS AND OTHER ITEMS RECEIVED
FOR DEPOSIT ARE SUBJECT TO THE TERMS AND
CONDITIONS OF I.C.B.'S FUNDS AVAILABILITY

ENTER TOTAL ON THE FRONT OF THIS TICKET

[illegible]

PLEASE ENDORSE ALL CHECKS
CHECKS LIST SINGLY

WITHDRAWAL FROM
INDEPENDENCE
COMMUNITY BANK

To: 570034504

8/5/2005

[Signature]

FOR:

- ☐ RETURNED CHECK
☐ LOAN DELINQUENCY
☐ DIVIDEND REMITTANCE
☐ PRINCIPAL PAYOUT
☐ PREM. PAYT.-S.B.L.I.

AMOUNT \$ 166,706.87

Charge to Account No. 108007053001

Depositor's
Name

Maria Cicato / Diagnostic Cl.

Supervisor's
Approval

[Signature]

1073 REV. 6/99

INDEPENDENCE CI

WITHD


1108007053 001
\$166,706.87

Trans \$166,706.87

TOR ST

110/05248

0004
08/05/2005

DEPOSIT	Enter Your Account Number		1106011727	
	<input checked="" type="checkbox"/> Checking <input type="checkbox"/> Passbook Savings <input type="checkbox"/> Statement Savings <input type="checkbox"/> CD			
	Sign <u>Home Theater Assoc.</u>			
	Address _____			
	Date <u>9-14-05.</u>			
	 Independence <small>Independence Community Bank At Bank & Trust</small>			
	1071			

Cash			
Check	<i>transfer from</i>		
	110	800	705 3001
Total			
Less Cash Returned			
Deposit	100,000	00	

DEPOSITS MAY NOT BE AVAILABLE FOR IMMEDIATE WITHDRAWAL. CHECKS AND OTHER ITEMS RECEIVED FOR DEPOSIT ARE SUBJECT TO THE TERMS AND CONDITIONS OF I.C.B.'S FUNDS AVAILABILITY.

ENTER TOTAL ON THE FRONT OF THIS TICKET																		PLEASE ENDORSE ALL CHECKS CHECKS LIST SEPARATELY			
																		DOLLARS		CENTS	
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0004 110/05289 1106011727 \$100,000.00 DEPOSIT CL

09/14/2005 TDR

INDEPENDENCE COMMUNITY BANK

WITHDRAWAL

Enter Your Account Number

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Amt \$ _____

☐ Checking ☐ Passbook Savings ☐ Statement Savings ☐ CD

Pay the amount of

0004 110/05189 1108007053 001
09/14/2005 \$100,000.00 WITHDRAWAL CD
Sign TOR ST Date
11205 \$100,000.00

Address _____ INDEPENDENCE COMMUNITY BANK

1072  **Independence**
Community Bank

WITHDRAWAL

WITHDRAWAL FROM
INDEPENDENCE
COMMUNITY BANK

Transfer to
1106011727

authorization
attached

Charge to Account No. 1108007053001

FOR:

☐ RETURNED CHECK
☐ LOAN DELINQUENCY
☐ DIVIDEND REMITTANCE
☐ PRINCIPAL PAYOUT
☐ PREM. PAYT.-S.B.L.I.

AMOUNT \$100,000 00

Depositor's Name Mario A. Criscito, M.D.

Supervisor's Approval 

1073 REV. 6/99

10d

FROM:

09-14-05 05:48 10:21:11 AM

MARIO A. CRISCITO, M.D.

9/14/2005

Dear Miss Garry

Please be so kind as to

Transfer one hundred Thousand dollars (\$100,000.00)

from my Acct # 01108007053001 into


Home Theater Architects Acct # 1106011727

Thank you
Mario A. Criscito

Fax # 973-5351293

Phone # 973 5350578

32 CHELSEA DRIVE LIVINGSTON, NEW JERSEY 07030-3420
TEL. 973-994-0880; FAX. 973-994-1908

DEPOSIT	Enter Your Account Number		570034504	
	<input type="checkbox"/> Checking <input type="checkbox"/> Passbook Savings <input type="checkbox"/> Statement Savings <input type="checkbox"/> CD			
	Sign <u>Mario Criscito</u>			
	Address _____			
	Date <u>11-28-05</u>			
 Independence. <small>Independence Community Bank AT Branch & Trust</small>		1071		

Cash		
Check	100,000	—
	<i>Transfer from</i>	
Total	<i>CD 570034504</i>	
Less Cash Returned	1108007053	
Deposit	100,000	—

DEPOSITS MAY NOT BE AVAILABLE FOR IMMEDIATE WITHDRAWAL. CHECKS AND OTHER ITEMS RECEIVED FOR DEPOSIT ARE SUBJECT TO THE TERMS AND CONDITIONS OF I.C.B.'S FUNDS AVAILABILITY.

PLEASE ENDORSE ALL CHECKS CHECKS LIST SEPARATELY																																																																																																																																																													
ENTER TOTAL ON THE FRONT OF THIS TICKET																																																																																																																																																													
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WITHDRAWAL FROM
INDEPENDENCE
COMMUNITY BANK

Transfer to
570034504

FOR:

- ☐ RETURNED CHECK
☐ LOAN DELINQUENCY
☐ DIVIDEND REMITTANCE
☐ PRINCIPAL PAYOUT
☐ PREM. PAYT.-S.B.L.I.

AMOUNT \$ *100,000* -

Charge to Account No. *110 8007053001*

Depositor's
Name *Alfredo Criscite*

Supervisor's
Approval *[Signature]*

1073 REV. 8/99

0079
11/28/2005

110/05177
TOR

570034504
\$100,000.00

DEPO:

INDEPENDENCE C

DEPOSIT	Enter Your Account Number																																
	<div style="display: flex; justify-content: space-around;"> <div style="border: 1px solid black; padding: 2px;">5</div> <div style="border: 1px solid black; padding: 2px;">7</div> <div style="border: 1px solid black; padding: 2px;">0</div> <div style="border: 1px solid black; padding: 2px;">0</div> <div style="border: 1px solid black; padding: 2px;">3</div> <div style="border: 1px solid black; padding: 2px;">4</div> <div style="border: 1px solid black; padding: 2px;">5</div> <div style="border: 1px solid black; padding: 2px;">0</div> <div style="border: 1px solid black; padding: 2px;">4</div> <div style="border: 1px solid black; padding: 2px;"> </div> <div style="border: 1px solid black; padding: 2px;"> </div> <div style="border: 1px solid black; padding: 2px;"> </div> </div>																																
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Check																																	
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Total																																	
Less Cash Returned																																	
Deposit	150,000	/																															
<small>DEPOSITS MAY NOT BE AVAILABLE FOR IMMEDIATE WITHDRAWAL. CHECKS AND OTHER ITEMS RECEIVED FOR DEPOSIT ARE SUBJECT TO THE TERMS AND CONDITIONS OF L.C.B.'S FUNDS AVAILABILITY.</small>																																	

PLEASE ENDORSE ALL CHECKS
CHECKS LIST SEPARATELY

	DOLLARS	CENTS
1	0037	
2	12/10/2005	
3		
4	110/05476	
5		
6		
7		
8		
9		
10	570034504	
11	8150,000.00	
12		
13		
14		
15	DEPOSIT	
16		
17	CR	
18		
TOTAL		

ENTER TOTAL ON THE FRONT OF THIS TICKET

WITHDRAWAL

Enter Your Account Number

1108007053001

Amt \$ 150,000.00

☐ Checking ☐ Passbook Savings ☐ Statement Savings ☒ CD

Deposit into

Pay the amount of

One hundred fifty thousand

570034504

Sign

[Signature]

Date 12/10/05

Address



1072

WITHDRAWAL

22-2323990

G037
12/10/2005

110/05476

TOR ST
Trans \$150,000.00

1108007053 001
\$150,000.00

WITHDRAWAL CD

INDEPENDENCE COMMUNITY BANK

DEPOSIT

Enter Your Account Number

5	1	0	0	3	4	1	0	4
---	---	---	---	---	---	---	---	---

☐ Checking
 ☐ Passbook Savings
 ☐ Statement Savings
 ☐ CD

Sign [Signature]

Address 32 Chelsea Dr.

Date 1/27/06

Independence
Independent Community Bank
 A Bank & Trust

1071

Cash		
Check	100,000	—
Total		
Less Cash Returned		
Deposit		

DEPOSIT

DEPOSITS MAY NOT BE AVAILABLE FOR IMMEDIATE WITHDRAWAL. CHECKS AND OTHER ITEMS RECEIVED FOR DEPOSIT ARE SUBJECT TO THE TERMS AND CONDITIONS OF I.C.B.'S FUNDS AVAILABILITY.

PLEASE ENDORSE ALL CHECKS
CHECKS LIST SHIRLEY

	DOLLARS	CENTS
1	0032	
2	01/27/2006	
3		
4	10/05/76	
5	TOP	
6		
7		
8		
9	510034504	
10	8100,000.00	
11		
12		
13		
14		
15	DEPOSIT	
16		
17		
18		
TOTAL		

ENTER TOTAL ON THE FRONT OF THIS TICKET

WITHDRAWAL

Enter Your Account Number
1108007053 Amt \$ 100,000

☐ Checking ☐ Passbook Savings ☐ Statement Savings ☐ CD

Pay the amount of
one hundred thousand 00/100

Sign [Signature] Date 1/27/06

Address 32 Chelsea Dr Livingston

Independence
Independence Community Bank
A Bank & Trust

1072

WITHDRAWAL

INDEPENDENCE COMMUNITY BANK

0033 01/27/2006 110/05476 1108007053 001 \$100,000.00 WITHDRAWAL CD
FOR ST \$100,000.00 TRANS

DEPOSIT

Enter Your Account Number

1	1	0	6	0	1	1	2	2	7
---	---	---	---	---	---	---	---	---	---

☐ Checking
 ☐ Passbook Savings
 ☐ Statement Savings
 ☐ CD

Sign: Home Theater

Address: _____

Date: 2-8-06

Independence
Independence Community Bank
A Bank & Trust

1071

Cash	
Check	<i>Transfer</i>
Total	
Less Cash Returned	
Deposit	15,000 00

DEPOSITS MAY NOT BE AVAILABLE FOR IMMEDIATE WITHDRAWAL. CHECKS AND OTHER ITEMS RECEIVED FOR DEPOSIT ARE SUBJECT TO THE TERMS AND CONDITIONS OF I.C.B.'S FUNDS AVAILABILITY.

DEPOSIT

ENTER TOTAL ON THE FRONT OF THIS TICKET

1	0054	02/08/2006	
2			
3			
4			
5			
6			
7			
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11			
12			
13			
14			
15			
16			
17			
18			
TOTAL			

PLEASE ENDORSE ALL CHECKS
CHECKS LIST SEPARATELY

WITHDRAWAL FROM
INDEPENDENCE
COMMUNITY BANK

Transfer to
1106011727
As Per Dr. Priscio
By phone w/ M. Coccoziello

FOR:

- ☐ RETURNED CHECK
☐ LOAN DELINQUENCY
☐ DIVIDEND REMITTANCE
☐ PRINCIPAL PAYOUT
☐ PREM. PAYT.-S.B.L.I.

AMOUNT \$15,000 00

Charge to Account No. 1108007053001

Depositor's
Name

Diagnostic & Clinical Cardiology

Supervisor's
Approval

[Signature]

1073 REV. 6/99

Enter Your Account Number

--	--	--	--	--	--	--	--	--	--

Amt. \$

- ☐ Checking ☐ Passbook ☐ Statement ☐ CD
Savings Savings

Pay the amount of

0054
02/08/2006

110/05946

1108007053 001

\$15,000.00

WITHDRAWAL CD

Sign

TOR ST

Trans \$15,000.00

Date

Address

INDEPENDENCE COMMUNITY BANK



Independence

Community Bank

1072

WITHDRAWAL

WITHDRAWAL

DEPOSITS MAY NOT BE AVAILABLE FOR IMMEDIATE WITHDRAWAL. CHECKS AND OTHER ITEMS RECEIVED FOR DEPOSIT ARE SUBJECT TO THE TERMS AND CONDITIONS OF L.C.B.'S FUNDS AVAILABILITY.

ENTER TOTAL ON THE FRONT OF THIS TICKET

	DOLLARS	CENTS
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
TOTAL		

0006
02/05/2000

10/05/76

106911727

305,000.00

DEPOSIT

CA

INDEPENDENCE COMMUNITY BANK

PLEASE ENDORSE ALL CHECKS
CHECKS LIST SEPARATELY

WITHDRAWAL FROM
INDEPENDENCE
COMMUNITY BANK

Transfer to
110 60 11 72 7

Call from Dr. Cristoforo
With Mira Cocozzello

FOR:

- ☐ RETURNED CHECK
☐ LOAN DELINQUENCY
☐ DIVIDEND REMITTANCE
☐ PRINCIPAL PAYOUT
☐ PREM. PAYT.-S.B.L.I.

AMOUNT \$ *35,000*

Charge to Account No. *110-8007053001*

Depositor's
Name

Diagnostic & Clinical Cardiology

Supervisor's
Approval

Mira Cocozzello

1073 REV. 6/99

WITHDRAWAL

Enter Your Account Number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Amt \$ _____

☐ Checking ☐ Passbook Savings ☐ Statement Savings ☐ CD

Pay the amount of


0005 110/05476 1108007053 001
02/09/2006
Sign *TCR ST* \$35,000.00 WITHDRAWAL CC
Trans \$35,000.00 Date _____

Address _____ INDEPENDENCE COMMUNITY BANK

 **Independence**
Community Bank

1072

WITHDRAWAL

Enter Your Account Number																			
1	1	0	8	0	0	7	0	5	2001										
<input type="checkbox"/> Checking					<input type="checkbox"/> Passbook Savings					<input type="checkbox"/> Statement Savings					<input checked="" type="checkbox"/> CD				
Sign <u>[Signature]</u>																			
Address _____																			
Date <u>4/1/06</u>																			
 Independence <small>Independence Community Bank a Bank & Trust</small>																			

Cash		
Check	66,000	—
Total		
Less Cash Returned		
Deposit	66,000	—

DEPOSITS MAY NOT BE AVAILABLE FOR IMMEDIATE WITHDRAWAL. CHECKS AND OTHER ITEMS RECEIVED FOR DEPOSIT ARE SUBJECT TO THE TERMS AND CONDITIONS OF I.C.B.'S FUNDS AVAILABILITY.

WITHDRAWAL

Enter Your Account Number

0570034504

Amt \$ 66,000.00

☒ Checking ☐ Passbook ☐ Statement ☐ CD
Savings Savings

Pay the amount of

On US\$ 5330 TNT 1108007053 001

0010
04/06/2006

110/05946

0570034504

\$66,000.00

ON US \$ 5330
WITHDRAWAL CK

Date

Sign

Address

INDEPENDENCE COMMUNITY BANK



Independence
Community Bank

1072

WITHDRAWAL

PERSONAL CHECKING ACCOUNT DEPOSIT TICKET

NAME Mario Criscito

ACCOUNT NUMBER * 57 0034 504

DATE 5-5-06

PAYMENT MAY NOT BE AVAILABLE FOR IMMEDIATE WITHDRAWAL

NON-RECEIPT IF CASH RECEIVED FROM DEPOSIT

Independence
Independence Community Bank
A Regis & Title

CASH -

CHECKS 100 000.00

CHECKS OR TOTAL FROM OTHER SIDE -

SUB TOTAL -

LESS CASH -

NET PAYMENT \$ 100 000.00

Transfer from 1108007053-001

⑆5319⑉0630⑆

CHEROKEE

05/05/2006 110/05946 810034504 \$100,000.00 DEPOSIT

INDEPENDENCE COMMUNITY BANK

TOTAL

SAVINGS WITHDRAWAL

CD
ACCOUNT NUMBER * 11100007053001 DATE 5-5-06

NAME Diagnostic & Clinical Cardiology Mario Criscito, Trustee \$ 100000.00

One hundred Thousand DOLLARS

ALL ITEMS SUBJECT TO RULES AND REGULATIONS
PERTAINING TO SAVINGS ACCOUNTS.

Independence
Independence Community Bank
21 Park St. Boston

Transfer to NON NEGOTIABLE 4504

SIGNATURE [Signature]

WITHDRAWALS ARE PERMITTED ONLY THROUGH PAYMENT
TO THE PERSONS AUTHORIZED ON THE ACCOUNT.

⑆5319⑈0950⑆

INDEPENDENCE COMMUNITY BANK

CD WITHDRAWAL

1108007053 001
\$100,000.00

Trans \$100,000.00

FOR ST

110/05946

05/05/2006
0100

INDEPENDENCE COMMUNITY BANK
TELLER CHECK
332691247

Pay To The Order Of SHORT HILLS WEST

Date 08/03/2006

Twenty Thousand Dollars

Memo D. Seisato

Drawn: Independence Community Bank
Pay to the order of: D. Seisato

Two Signatures Required for
Amount \$20,000.00

⑈254399⑈ ⑆102000979⑆ 25003326912479⑈ ⑈0002000000⑈

ED
1020-00199
6946
6103756486

1PS
DATA SET
SOURCE RELEASE
6103756486

0064906

STW

For deposit only

STW


SAVINGS WITHDRAWAL *Short Hills West*


ACCOUNT NUMBER * 11108007053001 DATE 6-3-06

NAME Diagnostic & Critical Cardiology \$ 20000.00

Twenty Thousand DOLLARS

ALL ITEMS SUBJECT TO RULES AND REGULATIONS PERTAINING TO SAVINGS ACCOUNTS. **NON NEGOTIABLE**

 **Independence**
Independence Community Bank
A Bank & Trust

SIGNATURE 

WITHDRAWALS ARE PERMITTED ONLY THROUGH PAYMENT TO THE PERSONS AUTHORIZED ON THE ACCOUNT

⑆5319⑉0950⑆

INDEPENDENCE COMMUNITY BANK

1108007053 001
AVAILABLE \$20,000.00
BALANCE \$3,772,152.20
WITHDRAWAL \$3,772,152.20
CD

110/05946
TOR ST

0012
06/03/2006

PERSONAL CHECKING ACCOUNT DEPOSIT TICKET

NAME Mario Criscito

ACCOUNT NUMBER
* 570034504

DATE 7-5-06

PAYMENT MAY NOT BE AVAILABLE FOR IMMEDIATE WITHDRAWAL

SHOW HERE IF CASH RECEIVED FROM DEPOSITOR

Independence
Independence Community Bank
Member FDIC

CASH - transfer from 1108007053001

CHECKS -

CHECKS OR TOTAL FROM OTHER SIDE -

SUB TOTAL -

LESS CASH -

NET PAYMENT \$ 130,000.00

⑆5319⑉0630⑆

INDEPENDENCE COMMUNITY BANK

07/05/2006 1108007053001

1108007053001

130,000.00

570034504

DEPOSIT

CK

TOTAL

⑆5319⑉0630⑆


SAVINGS WITHDRAWAL

ACCOUNT NUMBER * 11080197033001 h DATE 6/30/06

NAME DIAGNOSTIC + CLINICAL Radiology \$ 130,000.00
One hundred thirty thousand = 130,000 DOLLARS

ALL ITEMS SUBJECT TO RULES AND REGULATIONS
PERTAINING TO SAVINGS ACCOUNTS.

NON NEGOTIABLE

 **Independence**
Independence Community Bank
101 Main & 2nd
Transfer to
570034504
1:5319009501:

SIGNATURE [Signature]

WITHDRAWALS ARE PERMITTED ONLY THROUGH PAYMENT
TO THE PERSONS AUTHORIZED ON THE ACCOUNT.

INDEPENDENCE COMMUNITY BANK

CD WITHDRAWAL

1108067953 001
\$130,000.00

Trans \$130,000.00

110/09482

0002
07/05/2006

Transfer to 570034504

NAME Conza Builders, LLC CURRENCY Transfer
ACCOUNT NUMBER 1108019082001 COINS from
SAVINGS DEPOSIT DATE 7-14-06 CHECKS 110,800.7053001
SUB TOTAL \$ 262,000.00
LESS CASH 0.00
TOTAL \$ 262,000.00
⑈5319⑈0750⑈

ALL ITEMS ARE SUBJECT TO OUR RULES AND REGULATIONS PERTAINING TO SAVINGS ACCOUNTS.
DEPOSITS MAY NOT BE AVAILABLE FOR IMMEDIATE WITHDRAWAL.

Independence
by Independence Community Bank
To Build A Dream

INDEPENDENCE COMMUNITY BANK

07/14/2006 110/05946 108 NB 1108019082 001 \$262,000.00 DEPOSIT CD

SAVINGS WITHDRAWAL

ACCOUNT
NUMBER *

111081007993001

DATE 7-14-06

NAME

Mario Crisato Pension Fund \$ 262,000.00

Two Hundred Sixty two Thousand

DOLLARS

ALL ITEMS SUBJECT TO RULES AND REGULATIONS
PERTAINING TO SAVINGS ACCOUNTS.

NON NEGOTIABLE

 **Independence**

Transfers Independence Community Bank
at Bank & Trust

to 1108019082001

SIGNATURE



WITHDRAWALS ARE PERMITTED ONLY THROUGH PAYMENT
TO THE PERSONS AUTHORIZED ON THE ACCOUNT

⑆5369⑈0950⑆

INDEPENDENCE COMMUNITY BANK

WITHDRAWAL CD

1108007053 001
\$262,000.00

Trans
108 ST
\$262,000.00

110/05946

07/14/2006
0938

NAME Corra Builders LLC CURRENCY ☐
ACCOUNT NUMBER * 1108019389001 COINS ☐
SAVINGS DEPOSIT DATE 2-4-06 CHECKS ☒ 30 000 00
ALL ITEMS ARE SUBJECT TO OUR RULES AND REGULATIONS PERTAINING TO SAVINGS ACCOUNTS. DEPOSITS MAY NOT BE AVAILABLE FOR IMMEDIATE WITHDRAWAL. SUB TOTAL ☐
INDEPENDENCE ☐ LESS CASH ☐
\$ 30 000 00
⑆5319⑉0750⑆

INDEPENDENCE COMMUNITY BANK

CD DEPOSIT

\$30,000.00
1108019389 001

110/05986
TOR NB

1100
98/04/2006


SAVINGS WITHDRAWAL *Tr to 110 8019389001*

ACCOUNT NUMBER * 11017007053001 DATE 8-4-06

NAME Diagnostic & clinical
Mario Prácto Trety \$ 30000.00

Thirty Thousand and 00/100 DOLLARS

ALL ITEMS SUBJECT TO RULES AND REGULATIONS
PERTAINING TO SAVINGS ACCOUNTS. **NON NEGOTIABLE**

 **Independence**
Independence Community Bank
of Bank in Texas

SIGNATURE *[Signature]*

WITHDRAWALS ARE PERMITTED ONLY THROUGH PAYMENT
TO THE PERSONS AUTHORIZED ON THE ACCOUNT.

1108007053001

INDEPENDENCE COMMUNITY BANK

0011 08/04/2006 110/05986 1108007053 001 \$30,000.00 WITHDRAWAL CD TRANS \$30,000.00 TDR ST

PERSONAL CHECKING ACCOUNT DEPOSIT TICKET

NAME Mario Criscito

ACCOUNT NUMBER

* 0570034504

DATE 8-21-06

PAYMENT MAY NOT BE AVAILABLE FOR CASH/DATE WITHDRAWAL

SEE NOTE TO CARD* RETURNED FROM DEPOSIT



Independence Community Bank
111 Main St., Troy, NY 12180

CASH -

C
H
E
C
K
S

388,916.84

CHECKS OR TOTAL
FROM OTHER SIDE -

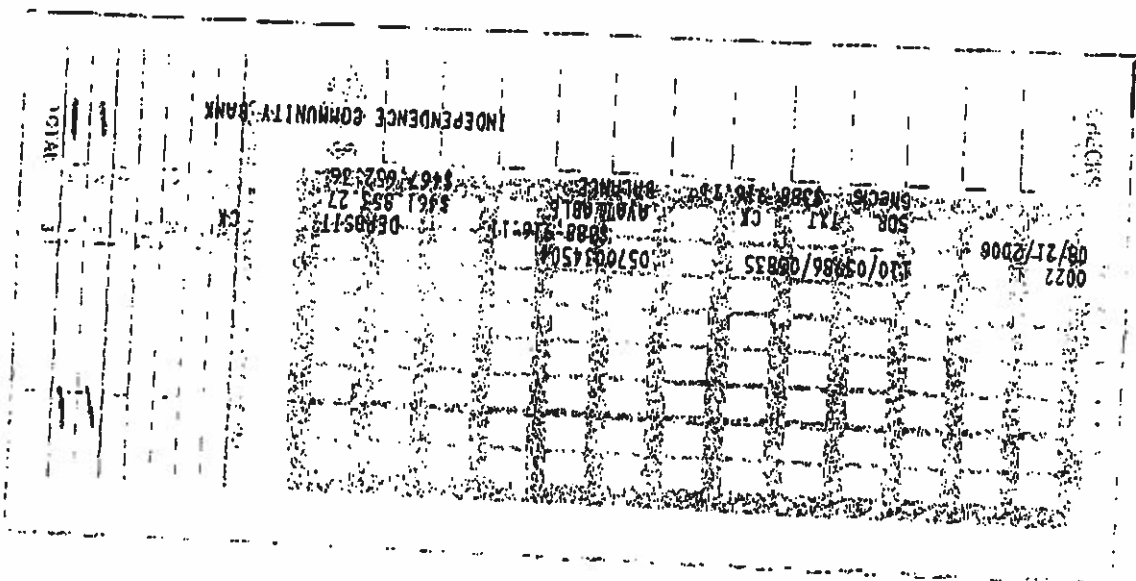
SUB TOTAL -

LESS CASH -

NET
PAYMENT

\$ 388,916.84

⑆5319⑈0630⑆



POD 409 REV. 03/04 Y4VAT1328

NAME Mario A. Cresato IRA Trust CURRENCY \$

ACCOUNT NUMBER * 1108019512001 CORRECTION 3,000,000.00

SAVINGS DEPOSIT DATE 8-21-06 CHECKS 0

ALL FUNDS ARE SUBJECT TO CREDIT REVIEW AND HOLDING PERIODS TO THE BANK'S ACCOUNT. DEPOSITS MAY NOT BE AVAILABLE FOR WITHDRAWAL IN THE MORNING.

Independence
A Division of Community Bank
Member FDIC

SUB TOTAL 3,000,000.00

LESS CASH 0

\$ 3,000,000.00

15319007501

INDEPENDENCE COMMUNITY BANK

110/05986/05835
SOL ST CK
Checks \$3,000,000.00
AVAILABLE
BALANCE
\$3,000,000.00
DEPOSIT
\$3,000,000.00

08/21/2006

SAVINGS WITHDRAWAL

ACCOUNT NUMBER * 1110 800 7053 001 DATE 8/1/06

NAME P.C.C. Pension Fund Mario Priscito, Trustee \$ BBB891611

Three Million ~~Four~~ Hundred Eighty Eight Thousand Nine Hundred Sixteen DOLLARS

ALL ITEMS SUBJECT TO RULES AND REGULATIONS PERTAINING TO SAVINGS ACCOUNTS. NON NEGOTIABLE \$ 84100

Independence
and Independence Community Bank
100 Bank & Trust

CK# _____ SIGNATURE Mario Priscito

WITHDRAWALS ARE PERMITTED ONLY THROUGH PAYMENT TO THE PERSONS AUTHORIZED ON THE ACCOUNT

⑆5319⑈0950⑆ CK# _____

INDEPENDENCE COMMUNITY BANK

WITHDRAWAL CD

\$3,388,916.11
1108007053 001

TOR ST CL

110/05986

0017
08/21/2006

EXHIBIT 66

Instructions to Participant

Note: If you postponed making a contribution to your IRA or certain retirement plans, in the box to the left of box 10, there should be a reason code, the year to which the contribution was credited, and the amount of the contribution.

The information on Form 5498 is submitted to the Internal Revenue Service by the trustee or issuer of your individual retirement arrangement (IRA) to report contributions, including any catch-up contributions, and the fair market value of the account. For information about IRAs, see Pub. 590, Individual Retirement Arrangements (IRAs), and Pub. 590, Retirement Plans for Small Business (SEP, SIMPLE, and Qualified Plans). Account number. May show an account or other unique number the payer assigned to distinguish your account.

Box 1. Shows traditional IRA contributions for 2006 you made in 2006 and through April 15, 2007. These contributions may be deductible on your Form 1040 or 1040A. However, if you or your spouse was an active participant in an employer's pension plan, these contributions may not be deductible. This box does not include amounts in boxes 2-4 and 6-10.

Box 2. Shows any rollover, including a direct rollover to a traditional IRA or Roth IRA, you made in 2006. It does not show any amounts you converted from your traditional IRA, SEP IRA, or SIMPLE IRA to a Roth IRA. They are shown in box 3. See the Form 1040 or 1040A instructions for information on how to report rollovers. If you have ever made any nondeductible contributions to your traditional IRA or SEP IRA and you did not roll over the total distribution, use Form 8606, Nondeductible IRAs, to figure the taxable amount. If property was rolled over, see Pub. 590.

Box 3. Shows the amount converted from a traditional IRA, SEP IRA, or SIMPLE IRA to a Roth IRA in 2006. Use Form 8606 to figure the taxable amount.

contribution (plus earnings) from one type of IRA to another. See Pub. 590.

Box 6. Shows the fair market value of your account at year end. However, if a decedent's name is shown, the amount reported may be the FMV on the date of death. If the FMV shown is zero for a decedent, the executor or administrator of the estate may request a date-of-death value from the financial institution.

Box 8. For endowment contracts only, shows the amount allocable to the cost of life insurance. Subtract this amount from your allowable IRA contribution included in box 1 to compute your IRA deduction.

Box 7. May show the kind of IRA reported on this Form 5498.

Box 9. Shows SEP contributions made in 2006, including contributions made in 2006 for 2006, but not including contributions made in 2007 for 2006. If made by your employer, do not deduct on your income tax return. If you made the contributions as a self-employed person (or partner), they may be deductible. See Pub. 590.

Box 10. Shows SIMPLE contributions made in 2006. If made by your employer, do not deduct on your income tax return. If you made the contributions as a self-employed person (or partner), they may be deductible. See Pub. 590.

Box 10. Shows Roth IRA contributions you made in 2006 and through April 15, 2007. Do not deduct on your income tax return.

Box 11. If the box is checked, you must take a required minimum distribution (RMD) for 2007. An RMD may be required even if the box is not checked. The amount, or offer to compute the amount, and date of the RMD will be furnished to you by January 31 either on Form 5498 (in the blank box to the left of box 10) or in a separate statement. If you do not take the RMD for 2007, you are subject to a 50% excise tax on the amount not distributed. See Pub. 590 for details.

☐ CORRECTED (if checked)

TRUSTEE'S or ISSUER'S name, street address, city, state, and ZIP code SOVEREIGN BANK 10-411-IR1 PO BOX 12646 READING PA 19612-2646		1 IRA contributions (other than amounts in boxes 2-4 and 6-10) 3	OMB No. 1545-0747 2006 Form 5498
TRUSTEE'S or ISSUER'S name, street address, city, state, and ZIP code 10-411-IR1 PO BOX 12646 READING PA 19612-2646		2 Rollover contributions \$ 3,000,000.00	
TRUSTEE'S or ISSUER'S name, street address, city, state, and ZIP code 23-1237295	PARTICIPANT'S social security number 144-30-5764	3 Roth IRA conversion amount \$	4 Rollover contributions \$
PARTICIPANT'S name, street address, city, state, and ZIP code MARIO A CRISCITO IRA TR 32 CHELSEA DR LIVINGSTON NJ 07039-3420		5 Fair market value of account \$ 3,057,809.41	6 Life insurance cost included in box 1 \$
Account number (see instructions) 1144305764		7 IRA SEP SIMPLE Roth IRA <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	8 SEP contributions \$
		9 SIMPLE contributions \$	10 Roth IRA contributions \$
		11 If checked, required minimum distribution for 2007 <input type="checkbox"/>	

IRA
Contribution
Information

Copy B
For
Participant

This information
is being
furnished to
the Internal
Revenue
Service.

(keep for your records)

Department of the Treasury - Internal Revenue Service



EXHIBIT 67



SAVINGS WITHDRAWAL

ACCOUNT NUMBER * **111018007053** INDEPENDENCE CONTRACT 8/106

D.C. Pension Fund
Marjorie F. Scott \$33,876.11
Three Million Four Hundred Eighty Thousand Dollars \$ 3,387,611.00

ALL ITEMS SUBJECT TO RULES AND REGULATIONS PERTAINING TO SAVINGS ACCOUNTS.

NON NEGOTIABLE

Independence
Financial Services, Inc.
Member FDIC

CK# _____ SIGNATURE *Marjorie F. Scott*
WITHDRAWALS ARE PERMITTED ONLY THROUGH PAYMENT TO THE PERSONS AUTHORIZED ON THE ACCOUNT.

CK# **531909501**

EXHIBIT 68

Do Not Write 6969

Form 1096 Department of the Treasury Internal Revenue Service	Annual Summary and Transmittal of U.S. Information Returns	OMB No. 1545-0108 2005 (Rev. March 2005)
FILER'S name Diagnostic & Clinical Cardiology P.A. Profit Sharing Plan Street address (including room or suite number) 769 Northfield Avenue, Suite 220 City, state, and ZIP code West Orange, NJ 07052		Faxed & Mailed 10-13-06
Name of person to contact Brian Warnock Email address	Telephone number (908) 757-5151 x103 Fax number (908) 757-9644	For Official Use Only
1 Employer identification number 76-0810624	2 Social security number	3 Total number of forms 1
4 Federal income tax withheld \$ 0.00		5 Total amount reported with this Form 1096 \$ 4510543.84
Enter an "X" in only one box below to indicate the type of form being filed. If this is your final return, enter an "X" here <input type="checkbox"/>		
W-2G 32 <input type="checkbox"/>	1099 81 <input type="checkbox"/>	1099-C 78 <input type="checkbox"/>
1099-E 84 <input type="checkbox"/>	1099-T 83 <input type="checkbox"/>	1099-A 80 <input type="checkbox"/>
1099-B 79 <input type="checkbox"/>	1099-C 85 <input type="checkbox"/>	1099-CAP 73 <input type="checkbox"/>
1099-DIV 91 <input type="checkbox"/>	1099-G 88 <input type="checkbox"/>	1099-H 71 <input type="checkbox"/>
1099-INT 92 <input type="checkbox"/>	1099-LTC 93 <input type="checkbox"/>	
1099-MISC 95 <input type="checkbox"/>	1099-OID 96 <input type="checkbox"/>	1099-PATR 97 <input type="checkbox"/>
1099-Q 31 <input type="checkbox"/>	1099-R 98 <input checked="" type="checkbox"/>	1099-S 75 <input type="checkbox"/>
1099-SA 94 <input type="checkbox"/>	5498 28 <input type="checkbox"/>	5498-ESA 72 <input type="checkbox"/>
5498-SA 27 <input type="checkbox"/>		

Return this entire page to the Internal Revenue Service. Photocopies are not acceptable.

Under penalties of perjury, I declare that I have examined this return and accompanying documents, and, to the best of my knowledge and belief, they are true, correct, and complete.

Signature _____ Title _____ Date _____

Instructions

Purpose of form. Use this form to transmit paper Forms 1099, 1098, 5498, and W-2G to the Internal Revenue Service. Do not use Form 1096 to transmit electronically or magnetically. For magnetic media, see Form 4804, Transmission of Information Returns Reported Magnetically; for electronic submissions, see Pub. 1220, Specifications for Filing Forms 1098, 1099, 5498, and W-2G Electronically or Magnetically.

Who must file. The name, address, and TIN of the filer on this form must be the same as those you enter in the upper left area of Forms 1099, 1098, 5498, or W-2G. A filer includes a payer; a recipient of mortgage interest payments (including points) or student loan interest; an educational institution; a broker; a barter exchange; a creditor; a person reporting real estate transactions; a trustee or issuer of any individual retirement arrangement, a Coverdell ESA, an HSA, an Archer MSA (including a Medicare Advantage MSA); certain corporations; certain donees of motor vehicles, boats, and airplanes; and a lender who acquires an interest in secured property or who has reason to know that the property has been abandoned.

Preadressed Form 1096. If you received a preaddressed Form 1096 from the IRS with Package 1099, use it to transmit paper Forms 1099, 1098, 5498, and W-2G to the Internal Revenue Service. If any of the preprinted information is incorrect, make corrections on the form.

If you are not using a preaddressed form, enter the filer's name, address (including room, suite, or other unit number), and TIN in the spaces provided on the form.

When to file. File Form 1096 with Forms 1099, 1098, or W-2G by February 28, 2006. File Form 1096 with Forms 5498, 5498-ESA, and 5498-SA by May 31, 2006.

Where To File

Send all information returns filed on paper with Form 1096 to the following:

If your principal business, office or agency, or legal residence in the case of an individual, is located in

Use the following Internal Revenue Service Center address

Alabama, Arizona, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Texas, Virginia

Austin, TX 73301

Arkansas, Connecticut, Delaware, Kentucky, Maine, Massachusetts, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Vermont, West Virginia

Cincinnati, OH 45999

Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Oklahoma, South Carolina, South Dakota, Tennessee, Wisconsin

Kansas City, MO 64999

☐ CORRECTED (if checked)

PAYER'S name, street address, city, state, and ZIP code		1 Gross distribution		OMB No. 1545-0119		Distributions From Pensions, Annuities, Retirement or Profit-Sharing Plans, IRAs, Insurance Contracts, etc.	
Diagnostic & Clinical Cardiology P.A. Profit Sharing Plan 769 Northfield Avenue, Suite 220 West Orange, NJ 07052		\$ 4510543.84		2005			
		2a Taxable amount					
		\$ 0.00		Form 1099-R			
		2b Taxable amount not determined <input type="checkbox"/>		Total distribution <input checked="" type="checkbox"/>			
PAYER'S Federal identification number	RECIPIENT'S identification number	3 Capital gain (included in box 2a)		4 Federal income tax withheld		Copy C For Recipient's Records	
76-0810624	144-30-5764	\$		\$			
RECIPIENT'S name, address, city, state, and ZIP code Mario Criscito 32 Chelsea Drive Livingston, NJ 07039-3420		5 Employee contributions or insurance premiums		6 Net unrealized appreciation in employer's securities		This information is being furnished to the Internal Revenue Service.	
		\$		\$			
		7 Distribution code(s)	IRA/SEP/SIMPLE	8 Other			
		G	<input type="checkbox"/>	\$	%		
		9a Your percentage of total distribution %		9b Total employee contributions \$			
Account number (see instructions)		10 State tax withheld		11 State/Payer's state no.		12 State distribution	
		\$				\$	
		\$				\$	
		13 Local tax withheld		14 Name of locality		15 Local distribution	
		\$				\$	
		\$				\$	

Form 1099-R

MGA

(keep for your records)

Department of the Treasury - Internal Revenue Service

☐ CORRECTED (if checked)

PAYER'S name, street address, city, state, and ZIP code		1 Gross distribution		OMB No. 1545-0119		Distributions From Pensions, Annuities, Retirement or Profit-Sharing Plans, IRAs, Insurance Contracts, etc.	
Diagnostic & Clinical Cardiology P.A. Profit Sharing Plan 769 Northfield Avenue, Suite 220 West Orange, NJ 07052		\$ 4510543.84		2005			
		2a Taxable amount					
		\$ 0.00		Form 1099-R			
		2b Taxable amount not determined <input type="checkbox"/>		Total distribution <input checked="" type="checkbox"/>			
PAYER'S Federal identification number	RECIPIENT'S identification number	3 Capital gain (included in box 2a)		4 Federal income tax withheld		Copy 2 File this copy with your state, city, or local income tax return, when required.	
76-0810624	144-30-5764	\$		\$			
RECIPIENT'S name, address, city, state, and ZIP code Mario Criscito 32 Chelsea Drive Livingston, NJ 07039-3420		5 Employee contributions or insurance premiums		6 Net unrealized appreciation in employer's securities			
		\$		\$			
		7 Distribution code(s)	IRA/SEP/SIMPLE	8 Other			
		G	<input type="checkbox"/>	\$	%		
		9a Your percentage of total distribution %		9b Total employee contributions \$			
Account number (see instructions)		10 State tax withheld		11 State/Payer's state no.		12 State distribution	
		\$				\$	
		\$				\$	
		13 Local tax withheld		14 Name of locality		15 Local distribution	
		\$				\$	
		\$				\$	

25010

Form 1099-R

MCA

Department of the Treasury - Internal Revenue Service

NTF 0487

B2664

WONEPERF

EXHIBIT 69

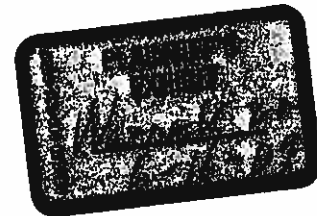
American Pension Corporation

1375 PLAINFIELD AVENUE • WATCHUNG, NEW JERSEY 07069
(908) 757-5151 • Facsimile (908) 757-9644

November 13, 2007

Joy M. Mercer, Esq.
Joy M. Mercer, P.C.
30 Columbia Turnpike
Florham Park, New Jersey 07932

Re: Diagnostic & Clinical Cardiology, P.A.
Profit Sharing Plan



Dear Ms. Mercer:

I received your letter of November 9, 2007 regarding Diagnostic & Clinical Cardiology. We are in the process of going through our files to accumulate the documentation that you have requested.

Regarding Item #4 of your letter, enclosed is a blank Benefit Election package, which is used by Diagnostic & Clinical Cardiology for plan distributions. Typically, the completed Election Forms are sent to Mary Sue McCarthy, to us, or to Diagnostic & Clinical Cardiology, P.A. The general procedure is, after our office reviews the Election Forms to make sure they are complete, Mary Sue McCarthy generates a letter of instruction which is signed by the Trustees. She then arranges to make the distribution from Morgan Stanley.

In the case of Mario Criscito, who was the Plan Trustee, he apparently provided the instructions for his own rollover directly to Morgan Stanley. He did not provide us with a copy of his Election Form, but did have Election Forms available to use.

Dr. Criscito did provide us with the dollar amount that was rolled over and we used that information to provide the 1099-R Form. While we certainly prefer that all Election Forms pass through our office, Dr. Criscito was the Plan Trustee, and, as such, had the authority to instruct Morgan Stanley to make the distribution. The only distribution for Dr. Criscito that we were aware of was the distribution of \$4,510,543.84. As such, that was the only 1099-R prepared for him by our office. I am unaware of what institution the rollover was made to, but I believe it was made to Morgan Stanley. Mary Sue McCarthy should have that information.

Dr. Casella has been to our office several times, and has had complete access to all of our files. In the process, a number of questions have come up which only Dr. Criscito, and possibly Morgan Stanley, have the answers to.

- 2 -

In the meantime, as I have assured Dr. Casella and the Plan Trustees on more than one occasion, you have our full cooperation. As you know, our responsibility is to the current Trustees, and we will do whatever we can to answer any questions you may have.

Sincerely,

A handwritten signature in black ink, appearing to read "Brian Warnock", with a stylized flourish at the end.

Brian P. Warnock
Vice-President

BPW/sjl

cc: Fadi Chaaban, M.D. (Plan Trustee)
Constantinos A. Costeas, M.D. (Plan Trustee)
Sabino R. Torre, M.D. (Plan Trustee)
Gary Rogal, M.D., President
Anthony Casella, M.D.
Mr. Mark Brown
Mr. Peter V. S. Coughlan, President
Ms. Dominique Eck, Pension Consultant

EXHIBIT 70

Form 5500
 Department of the Treasury
 Internal Revenue Service
 Department of Labor
 Pension and Welfare Benefits
 Administration
 Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan
 This form is required to be filed under sections 104 and 4085 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6038D, 6047(e), 6067(b), and 6059(a) of the Internal Revenue Code (the Code).
 Complete all entries in accordance with the instructions to the Form 5500.

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 02

Official Use Only
 OMB Nos. 1510-0110
 1510-0088

1999

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For the calendar plan year 1999 or fiscal plan year beginning and ending

A This return/report is for: (1) ☐ a multiemployer plan; (3) ☐ a multiple-employer plan;
 (2) ☒ a single-employer plan (other than a (4) ☐ a DFE (specify)

B This return/report is: (1) ☐ the first return/report filed for the plan; (3) ☐ the final return/report filed for the plan;
 (2) ☐ an amended return/report; (4) ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here

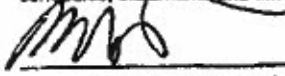
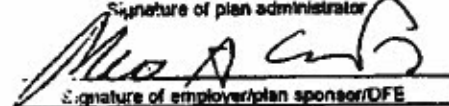
D If you filed for an extension of time to file, check the box and attach a copy of the extension application

Part II Basic Plan Information - enter all requested information.

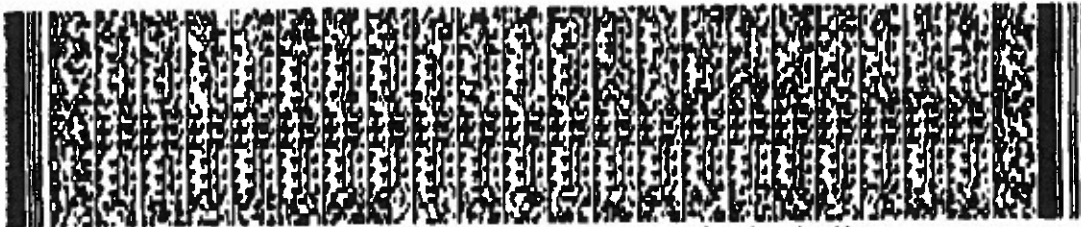
1a Name of plan DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN	1b Three-digit plan number (PN) 002
	1c Effective date of plan (mo., day, yr.) 04/01/1976
2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.) DIAGNOSTIC & CLINICAL CARDIOLOGY CARDIOLOGY, P.A. 769 NORTHFIELD AVENUE WEST ORANGE NJ 07052	2b Employer Identification Number (EIN) 22-2323990 2c Sponsor's telephone number 973-731-9442 2d Business code (see instructions) 621111

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

	10/15	MARIO CRISCITO, M.D.
Signature of plan administrator	Date	Typed or printed name of individual signing as plan administrator
	10/15	MARIO CRISCITO, M.D.
Signature of employer/plan sponsor/DFE	Date	Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. v2.3 Form 5500 (1999)



PLAINTIFF'S
 EXHIBIT
 CRISCITO 13
 12-4-09

Form 5500 (1999)

Page 2

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3a Plan administrator's name and address (If same as plan sponsor, enter "Same")
SAME

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN

c PN

5 Preparer information (optional) a Name (including firm name, if applicable) and address
AMERICAN PENSION CORPORATION

b EIN

22-2141197

c Telephone no.

1375 PLAINFIELD AVENUE

WATCHUNG

NJ

07069

908-757-5151

6 Total number of participants at the beginning of the plan year

6 24

7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

a Active participants

7a 15

b Retired or separated participants receiving benefits

7b 0

c Other retired or separated participants entitled to future benefits

7c 9

d Subtotal. Add lines 7a, 7b, and 7c

7d 24

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

7e 0

f Total. Add lines 7d and 7e

7f 24

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

7g 24

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

7h 0

i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)

7i 0

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☒ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes (printed in the instructions)): 2C 2G 3F

b ☐ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes (printed in the instructions)):

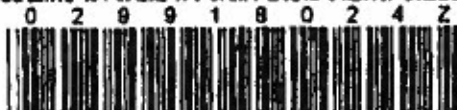
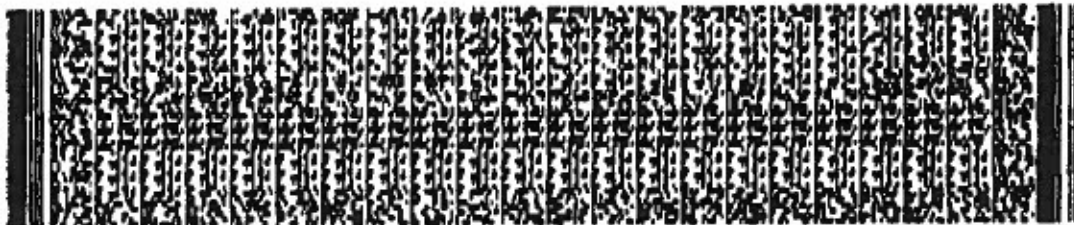
c ☐ Fringe benefits (check this box if the plan provides fringe benefits)

9a Plan funding arrangement (check all that apply)

- (1) ☒ Insurance
(2) ☐ Section 412(f) insurance contracts
(3) ☒ Trust
(4) ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- (1) ☒ Insurance
(2) ☐ Section 412(f) insurance contracts
(3) ☒ Trust
(4) ☐ General assets of the sponsor



Form 5500 (1998)

Page 3

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10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

- (1) ☒ R (Retirement Plan Information)
(2) ☒ 1 T (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan
is relying on coverage testing information for a
prior year, enter the year

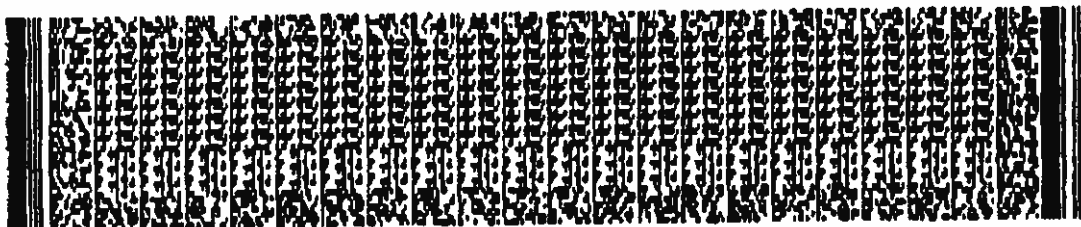
- (3) ☐ B (Actuarial Information)
(4) ☐ E (ESOP Annual Information)
(5) ☐ SSA (Separated Vested Participant Information)

b Financial Schedules

- (1) ☐ H (Financial Information)
(2) ☒ I (Financial Information - Small Plan)
(3) ☒ 2 A (Insurance Information)
(4) ☐ C (Service Provider Information)
(5) ☐ D (DFE/Participating Plan Information)
(6) ☐ G (Financial Transaction Schedules)
(7) ☒ 1 P (Trust Fiduciary Information)

c Fringe Benefit Schedule

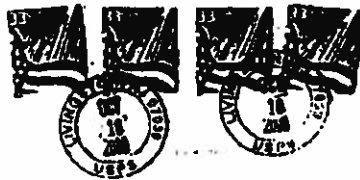
- ☐ F (Fringe Benefit Plan Annual Information)



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OMB No. 1210-0110

1999

This Form is Open to
Public Inspection

**SCHEDULE A
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits Administration
Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the
Employee Retirement Income Security Act of 1974.

File as an attachment to Form 5500.

Insurance companies are required to provide this information
pursuant to ERISA section 103(e)(2).

For the calendar year 1999 or fiscal plan year beginning and ending

A Name of plan DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN	B Three-digit plan number 002
C Plan sponsor's name as shown on line 2a of Form 5500 DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.	D Employer Identification Number 22-2323990

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions.

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be
reported on a single Schedule A.

1 Coverage:

(a) Name of insurance carrier

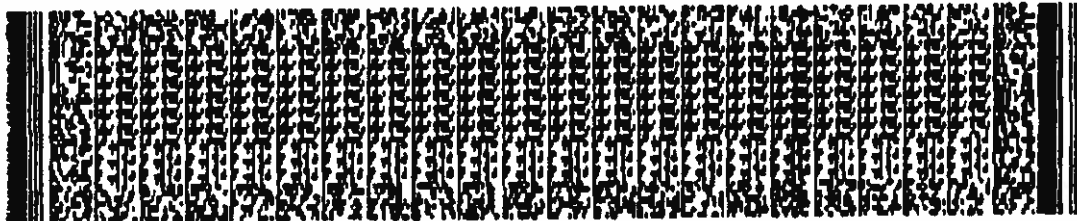
PROVIDENT MUTUAL

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
		4024790	1	01/01/1999	12/31/1999

2 Insurance fees and commissions paid to agents, brokers, and other persons:

Totals	
Amount of commissions paid	Fees paid / Amount
0	0

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. v2.3 Schedule A (Form 5500) 1999



Schedule A (Form 5500) 1998

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(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

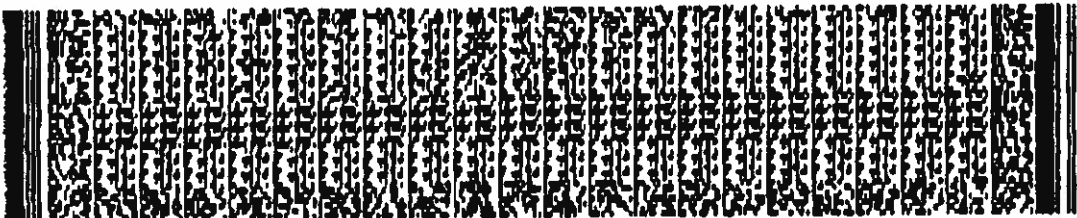
(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	



Schedule A (Form 5500) 1999

Page 3

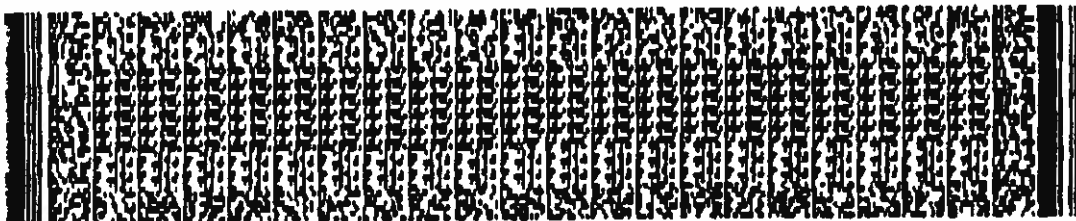
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Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

3	Current value of plan's interest under this contract in the general account at year end	
4	Current value of plan's interest under this contract in separate accounts at year end	
5	Contracts With Allocated Funds	
a	State the basis of premium rates	ON FILE WITH THE DEPT. OF INS.
b	Premiums paid to carrier	15,000
c	Premiums due but unpaid at the end of the year	0
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount	0
	Specify nature of costs	N/A
e	Type of contract (1) <input checked="" type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity (3) <input type="checkbox"/> other (specify)	
f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here	
6	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	
a	Type of contract (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee (3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other (specify below)	
b	Balance at the end of the previous year	
c	Additions: (1) Contributions deposited during the year (2) Dividends and credits (3) Interest credited during the year (4) Transferred from separate account (5) Other (specify below)	
	(6) Total additions	
d	Total of balance and additions (add b and c (6))	
e	Deductions: (1) Disbursed from fund to pay benefits or purchase annuities during year (2) Administration charge made by carrier (3) Transferred to separate account (4) Other (specify below)	
	(5) Total deductions	
f	Balance at the end of the current year (subtract e (5) from d)	



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Schedule A (Form 5500) 1998

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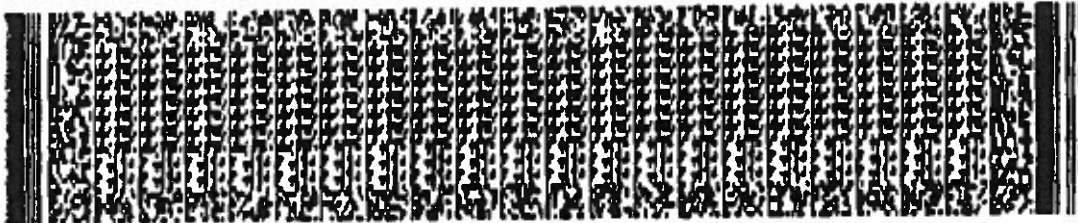
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Official Use Only

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes on this report.

7 Benefit and contract type (check all applicable boxes)			
<input type="checkbox"/> a Health (other than dental or vision)	<input type="checkbox"/> b Dental	<input type="checkbox"/> c Vision	<input type="checkbox"/> d Life insurance
<input type="checkbox"/> e Temporary disability (accident and sickness)	<input type="checkbox"/> f Long-term disability	<input type="checkbox"/> g Supplemental unemployment	<input type="checkbox"/> h Prescription drug
<input type="checkbox"/> i Stop loss (large deductible)	<input type="checkbox"/> j HMO contract	<input type="checkbox"/> k PPO contract	<input type="checkbox"/> l Indemnity contract
<input type="checkbox"/> m Other (specify) _____			

8 Experience-rated contracts		
a Premiums: (1) Amount received		
(2) Increase (decrease) in amount due but unpaid		
(3) Increase (decrease) in unearned premium reserve		
(4) Earned ((1) + (2) - (3))		
b Benefit charges: (1) Claims paid		
(2) Increase (decrease) in claim reserves		
(3) Incurred claims (add (1) and (2))		
(4) Claims charged		
c Remainder of premium: (1) Retention charges (on an accrual basis) --		
(A) Commissions		
(B) Administrative service or other fees		
(C) Other specific acquisition costs		
(D) Other expenses		
(E) Taxes		
(F) Charges for risks or other contingencies		
(G) Other retention charges		
(H) Total retention		
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)		
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		
(2) Claim reserves		
(3) Other reserves		
e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)		
9 Nonexperience-rated contracts:		
a Total premiums or subscription charges paid to carrier		
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount		
Specify nature of costs: _____		



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SCHEDULE A
(Form 5500)
Department of the Treasury
Internal Revenue Service
Department of Labor
Pension and Welfare Benefits Administration
Pension Benefits Quarterly Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

► File as an attachment to Form 5500.

► Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

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Official Use Only

OMB No. 1510-0110

1999

This Form is Open to Public Inspection

For the calendar year 1999 or fiscal plan year beginning and ending

A Name of plan DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN	<input checked="" type="checkbox"/> Three-digit plan number 002
C Plan sponsor's name as shown on line 2a of Form 5500 DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.	<input type="checkbox"/> Employer Identification Number 22-2323990

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions.

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage:

(a) Name of Insurance carrier

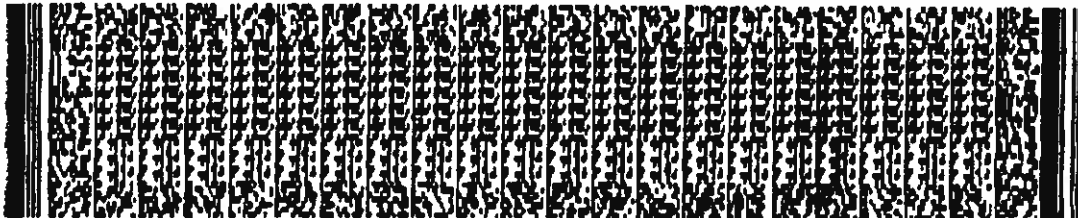
NEW YORK LIFE

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
		P8102530	1	01/01/1999	12/31/1999

2 Insurance fees and commissions paid to agents, brokers, and other persons:

Totals	
Amount of commissions paid	Fees paid / Amount
0	0

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. v2.3 Schedule A (Form 5500) 1999



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Schedule A (Form 5500) 1999

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(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

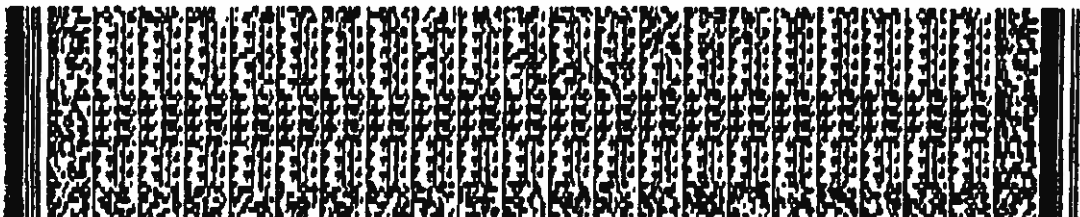
(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	



Schedule A (Form 5500) 1999

Page 3

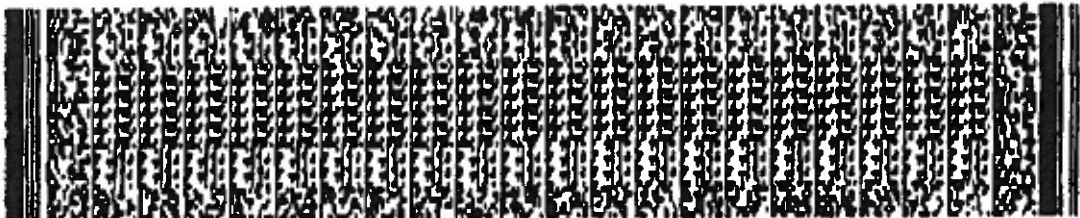
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Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

3 Current value of plan's interest under this contract in the general account at year end		
4 Current value of plan's interest under this contract in separate accounts at year end		
5 Contracts With Allocated Funds		
a State the basis of premium rates ON FILE WITH THE DEPT. OF INS.		
b Premiums paid to carrier		42,000
c Premiums due but unpaid at the end of the year		0
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount		0
Specify nature of costs N/A		
e Type of contract (1) <input checked="" type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity		
(3) <input type="checkbox"/> other (specify) 		
f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here <input type="checkbox"/>		
6 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)		
a Type of contract (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee		
(3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other (specify below) 		
b Balance at the end of the previous year		
c Additions: (1) Contributions deposited during the year		
(2) Dividends and credits		
(3) Interest credited during the year		
(4) Transferred from separate account		
(5) Other (specify below)		
(6) Total additions		
d Total of balance and additions (add b and c (6))		
e Deductions:		
(1) Disbursed from fund to pay benefits or purchase annuities during year		
(2) Administration charge made by carrier		
(3) Transferred to separate account		
(4) Other (specify below)		
(5) Total deductions		
f Balance at the end of the current year (subtract e (5) from d)		



Schedule A (Form 6500) 1999

Page 4

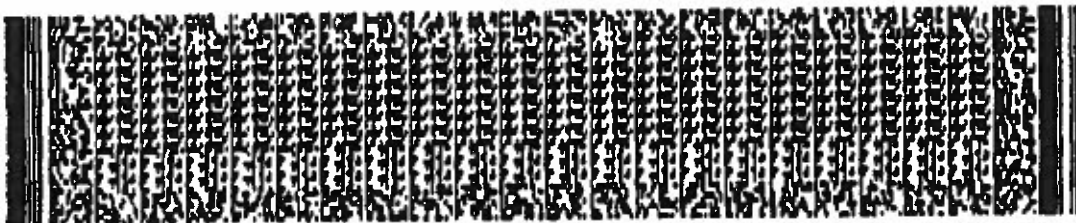
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Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes on this report.

7 Benefit and contract type (check all applicable boxes)			
<input type="checkbox"/> a Health (other than dental or vision)	<input type="checkbox"/> b Dental	<input type="checkbox"/> c Vision	<input type="checkbox"/> d Life Insurance
<input type="checkbox"/> e Temporary disability (accident and sickness)	<input type="checkbox"/> f Long-term disability	<input type="checkbox"/> g Supplemental unemployment	<input type="checkbox"/> h Prescription drug
<input type="checkbox"/> i Stop loss (large deductible)	<input type="checkbox"/> j HMO contract	<input type="checkbox"/> k PPO contract	<input type="checkbox"/> l Indemnity contract
<input type="checkbox"/> m Other (specify) _____			

8 Experience-rated contracts		
a Premiums: (1) Amount received		
(2) Increase (decrease) in amount due but unpaid		
(3) Increase (decrease) in unearned premium reserve		
(4) Earned ((1) + (2) - (3))		
b Benefit charges: (1) Claims paid		
(2) Increase (decrease) in claim reserves		
(3) Incurred claims (add (1) and (2))		
(4) Claims charged		
c Remainder of premium: (1) Retention charges (on an accrual basis) --		
(A) Commissions		
(B) Administrative service or other fees		
(C) Other specific acquisition costs		
(D) Other expenses		
(E) Taxes		
(F) Charges for risks or other contingencies		
(G) Other retention charges		
(H) Total retention		
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)		
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		
(2) Claim reserves		
(3) Other reserves		
e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)		
9 Nonexperience-rated contracts:		
a Total premiums or subscription charges paid to carrier		
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount		
Specify nature of costs _____		



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Official Use Only

OMB No. 1510-0110

1999

This Form is Open
to Public Inspection.

**SCHEDULE I
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits
Administration

Pension Benefit Guaranty Corporation

Financial Information - Small Plan

This schedule is required to be filed under Section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).

File as an attachment to Form 5500.

For calendar year 1999 or fiscal plan year beginning _____ and ending _____

A Name of plan
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN

B Three-digit plan number **002**

C Plan sponsor's name as shown on line 2a of Form 5500
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.

D Employer identification number
22-2323990

Complete Schedule I if the plan covered fewer than 100 participants as of the beginning of the plan year. You may also complete Schedule I if you are filing as a small plan under the 80-120 participant rule (see instructions). Complete Schedule H if reporting as a large plan or DFE.

Part I Small Plan Financial Information

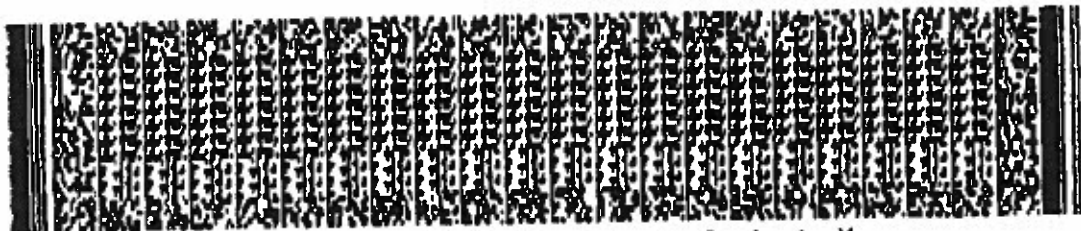
Report below the current value of assets and liabilities, income, expenses, transfers and changes in net assets during the plan year. Combine the value of plan assets held in more than one trust. Do not enter the value of the portion of an insurance contract that guarantees during this plan year to pay a specific dollar benefit at a future date. Include all income and expenses of the plan including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar.

		(a) Beginning of Year	(b) End of Year
1	Plan Assets and Liabilities:		
a	Total plan assets	6,601,582	8,194,766
b	Total plan liabilities		
c	Net plan assets (subtract line 1b from line 1a)	6,601,582	8,194,766
2	Income, Expenses, and Transfers for this Plan Year:	(a) Amount	(b) Total
a	Contributions received or receivable		
(1)	Employers	318,831	
(2)	Participants		
(3)	Others (including rollovers)		
b	Noncash contributions		
c	Other income		
d	Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	1,331,353	1,650,184
e	Benefits paid (including direct rollovers)		
f	Corrective distributions (see instructions)		
g	Certain deemed distributions of participant loans (see instructions)		
h	Other expenses	57,000	57,000
i	Total expenses (add lines 2e, 2f, 2g, and 2h)		1,593,184
j	Net income (loss) (subtract line 2i from line 2d)		0
k	Net transfers		

3 Specific Assets: If the plan held any assets in one or more of the following specific categories, check yes and enter the current value as of the end of the plan year. Allocate the value of the plan's interest in a commingled trust containing the assets of more than one plan on a line-by-line basis unless the trust meets one of the specific exceptions described in the instructions.

	Yes	No	Amount
a Partnership/joint venture interests		X	
b Employer real property		X	

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. v2.3 Schedule I (Form 5500) 1999



Schedule I (Form 990) 1999

Page 2

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	Yes	No	Amount
3c Real estate (other than employer real property)		X	
d Employer securities		X	
e Participant loans		X	
f Loans (other than to participants)		X	
g Tangible personal property		X	

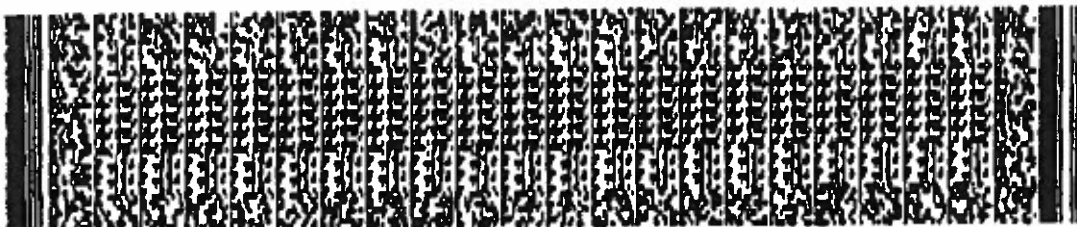
Part II Transactions During Plan Year

	Yes	No	Amount
4 During the plan year:			
a Did the employer fail to transmit to the plan any participant contributions within the maximum time period described in 29 CFR 2510.3-1027 (See instructions)		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by the participants' account balance		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible?		X	
d Did the plan engage in any nonexempt transaction with any party-in-interest?		X	
e Was the plan covered by a fidelity bond?	X		350,000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
i Did the plan at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest?		X	
j Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? If yes, enter the amount of any plan assets that reverted to the employer this year ☐ Yes ☒ No Amount

5b If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)	5b(2) EIN(s)	5b(3) PN(s)



**SCHEDULE P
(FORM 5500)**

Department of the Treasury
Internal Revenue Service

**Annual Return of Fiduciary
of Employee Benefit Trust**

This schedule may be filed to satisfy the requirements under section 6033(a) for an annual information return from every section 401(a) organization exempt from tax under section 501(a).

Filing this form will start the running of the statute of limitations under section 6501(a) for any trust described in section 401(a) that is exempt from tax under section 501(a).

File as an attachment to Form 5500 or 5500-EZ.

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Official Use Only

OMB No. 1510-0110

1999

This Form is Open to
Public Inspection.

For trust calendar year 1999 or fiscal year beginning , and ending

1a Name of trustee or custodian

MARIO CRISCITO, M.D.

b Number, street, and room or suite no. (If a P.O. box, see the instructions for Form 5500 or 5500-EZ.)

769 NORTHEFIELD AVENUE

c City or town, state, and ZIP code

WEST ORANGE

NJ 07052

2a Name of trust

DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN

b Trust's employer identification number 22-2323990

3 Name of plan if different from name of trust

4 Have you furnished the participating employee benefit plan(s) with the trust financial information required to be reported by the plan(s)?

☒ Yes

☐ No

5 Enter the plan sponsor's employer identification number as shown on Form 5500 or 5500-EZ

22-2323990

Under penalties of perjury, I declare that I have examined this schedule, and to the best of my knowledge and belief it is true, correct, and complete.

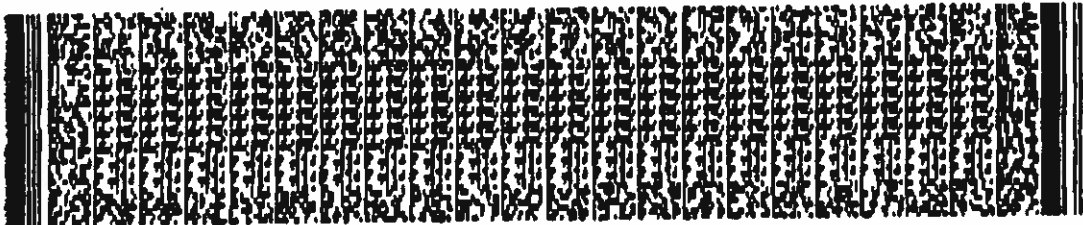
Signature of fiduciary

Date

v2.3

Schedule P (Form 5500) 1999

For the Paperwork Reduction Notice and OMB Control Numbers, see the instructions for Form 5500 or 5500-EZ.



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**SCHEDULE R
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits
Administration

Pension Benefit Guaranty Corporation

Retirement Plan Information

This schedule is required to be filed under sections 104 and 4085 of the Employee Retirement Security Act of 1974 (ERISA) and section 5058(a) of the Internal Revenue Code (the Code).

File as an Attachment to Form 5500.

OMB No. 1510-0110

1999

This Form Is Open to
Public Inspection.

For calendar year 1999 or fiscal plan year beginning and ending

A Name of plan DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN	B Three-digit plan number 002
C Plan sponsor's name as shown on line 2a of Form 5500 DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.	D Employer identification number 22-2323990

Part I Distributions

All references to distributions relate only to payments of benefits during the plan year.

- Total value of distributions paid in property other than in cash, annuity contracts, or publicly traded employer securities
- Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits).

Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.

- Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year

1	\$	
2		
3		

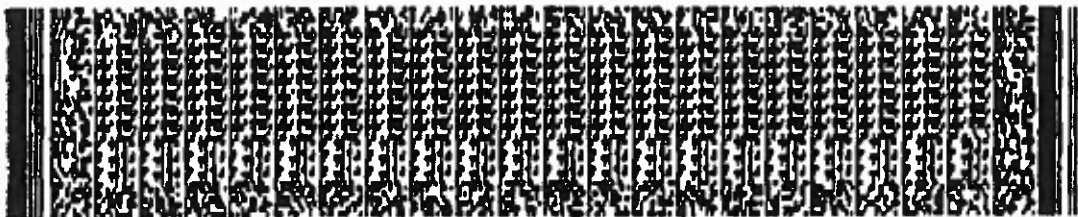
Part II Funding Information (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part.)

- Is the plan administrator making an election under Code section 412(c)(8) or ERISA section 302(c)(8)? ☐ Yes ☒ No ☐ N/A
If the plan is a defined benefit plan, go to line 7.
- If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the ruling letter granting the waiver ☐ Month ☐ Day ☐ Year
If you completed line 6, complete lines 3, 9, and 10 of Schedule B and do not complete the remainder of this schedule.
- Enter the minimum required contribution for this plan year **6a** \$ 318,831
- Enter the amount contributed by the employer to the plan for this plan year **6b** \$ 318,831
- Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount) **6c** \$ 0
If you completed line 6c, do not complete the remainder of this schedule.
- If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure providing automatic approval for the change, does the plan sponsor or plan administrator agree with the change? ☐ Yes ☐ No ☐ N/A
Do not complete line 8, if the plan is a multiemployer plan or a plan with 100 or fewer participants during the prior plan year (see inst.).
- Is the employer electing to compute minimum funding for this plan year using the transitional rule provided in Code section 412(l)(11) and ERISA section 302(d)(11)? ☐ Yes ☐ No ☐ N/A

Part III Amendments

- If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased the value of benefits? (see instructions) ☐ Yes ☐ No

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. v2.3 Schedule R (Form 5500) 1999



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Official Use Only

OMB No. 1510-0110

1999

This Form is Open
to Public Inspection.

**SCHEDULE T
(Form 5500)**

Department of the Treasury
Internal Revenue Service

Qualified Pension Plan Coverage Information

This form is required to be filed under section 6058(a) of the
Internal Revenue Code (the Code).

File as an attachment to Form 5500.

For calendar year 1999 or fiscal plan year beginning _____ and ending _____	
A Name of plan DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN	B Three-digit plan number 002
C Plan sponsor's name as shown on line 2a of Form 5500 DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.	D Employer identification Number 22-2323990

Note: If the plan is maintained by:

More than one employer and benefits employees who are not collectively-bargained employees, a separate Schedule T may be required for each employer (see the instruction for line 1).

An employer that operates qualified separate lines of business (QSLOBs) under Code section 414(r), a separate Schedule T may be required for each QSLOB (see the instruction for line 2).

- 1 If this schedule is being filed to provide coverage information regarding the noncollectively bargained employees of an employer participating in a plan maintained by more than one employer, enter the name and EIN of the participating employer:

1a Name of participating employer	1b Employer identification number
--	--

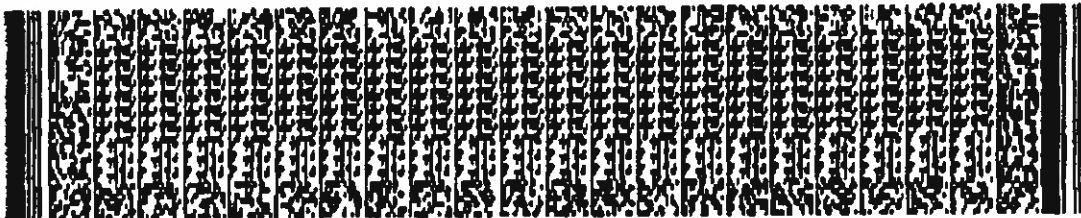
2 If the employer maintaining the plan operates QSLOBs, enter the following information:

- a The number of QSLOBs that the employer operates is _____
- b The number of such QSLOBs that have employees benefiting under this plan is _____
- c Does the employer apply the minimum coverage requirements to this plan on an employer-wide rather than a QSLOB basis? ☐ Yes ☐ No
- d If the entry on line 2b is two or more and line 2c is "No," identify the QSLOB to which the coverage information given on line 3 or 4 relates.

3 Exceptions - Check the box before each statement that describes the plan or the employer.
If you check any box, do not complete the rest of this Schedule.

- a ☐ The employer employs only highly compensated employees (HCEs).
- b ☐ No HCEs benefited under the plan at anytime during the plan year.
- c ☐ The plan benefits only collectively bargained employees.
- d ☒ The plan benefits all nonexcludable nonhighly compensated employees of the employer (as defined in Code sections 414(b), (c), and (m)), including leased employees and self-employed individuals.
- e ☐ The plan is treated as satisfying the minimum coverage requirements under Code section 410(b)(5)(C).

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. v2.3 Schedule T (Form 5500) 1999



Page 2

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1. The first step in the process is to identify the problem or issue that needs to be addressed. This involves gathering information and understanding the context of the problem.
2. Once the problem is identified, the next step is to define the objectives and goals of the project. This helps to clarify what needs to be achieved and provides a clear direction for the work.
3. The third step is to develop a plan or strategy to address the problem. This involves breaking down the problem into smaller, manageable tasks and determining the resources needed to complete them.
4. The fourth step is to implement the plan. This involves putting the strategy into action and monitoring progress to ensure that the objectives are being met.
5. The final step is to evaluate the results of the project. This involves assessing the outcomes against the objectives and identifying any areas for improvement or further action.

2 8 9 9 1 8 0 2 4 0



EXHIBIT 71

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Form **5500**
Department of the Treasury
Internal Revenue Service
Department of Labor
Pension and Welfare Benefits
Administration
Pension Benefits Guaranty Corporation

Annual Return/Report of Employee Benefit Plan
This form is required to be filed under sections 104 and 4086 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(c), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).
▶ Complete all entries in accordance with the instructions to the Form 5500.

Official Use Only
OMB Nos. 1510-0010
1510-0088

2000

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For the calendar plan year 2000 or fiscal plan year beginning

- A This return/report is for: (1) ☐ a multiemployer plan; (2) ☒ a single-employer plan (other than a multiple-employer plan); (3) ☐ a multiple-employer plan; or (4) ☐ a DFE (specify) _____
- B This return/report is: (1) ☐ the first return/report filed for the plan; (2) ☐ an amended return/report; (3) ☐ the final return/report filed for the plan; (4) ☐ a short plan year return/report (less than 12 months).
- C If the plan is a collectively-bargained plan, check here _____
- D If you filed for an extension of time to file, check the box and attach a copy of the extension application _____ ☒

Part II Basic Plan Information — enter all requested information.

1a Name of plan DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN	1b Three-digit plan number (PN) ▶ 002
	1c Effective date of plan (mo., day, yr.) 04/01/1976
2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.) DIAGNOSTIC & CLINICAL CARDIOLOGY CARDIOLOGY, P.A. 769 NORTHFIELD AVENUE WEST ORANGE NJ 07052	2b Employer identification number (EIN) 22-2323990
	2c Sponsor's telephone number 973-731-9442
	2d Business code (see instructions) 621111

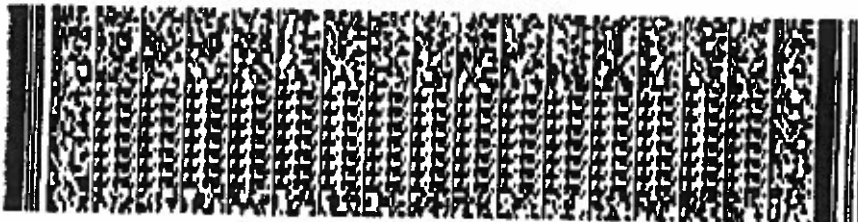
Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements, and attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

[Signature] 10/22/00 MARIO CRISCITO, M.D.
Signature of plan administrator Date Typed or printed name of individual signing as plan administrator

[Signature] 10/22/00 MARIO CRISCITO, M.D.
Signature of employer/plan sponsor/DFE Date Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. v3.2 Form 5500 (2000)



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PLAINTIFF'S
EXHIBIT
CRISCITO 14
12-4-09

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Form 5500 (2000)

Page 2

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3a Plan administrator's name and address (if same as plan sponsor, enter "Same")
SAME

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:

a Sponsor's name

b EIN

c PN

5 Preparer information (optional) a Name (including firm name, if applicable) and address
AMERICAN PENSION CORPORATION

b EIN

22-2141197

c Telephone number

1375 PLAINFIELD AVENUE

WATCHUNG

NJ 07069

908-757-5151

6 Total number of participants at the beginning of the plan year

6

26

7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)

a Active participants

7a

16

b Retired or separated participants receiving benefits

7b

0

c Other retired or separated participants entitled to future benefits

7c

1

d Subtotal. Add lines 7a, 7b, and 7c

7d

17

e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits

7e

0

f Total. Add lines 7d and 7e

7f

17

g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)

7g

17

h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested

7h

0

i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)

7i

0

8 Benefits provided under the plan (complete 8a through 8c, as applicable)

a ☒ Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions): 2C 2G 3Eb ☐ Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):c ☐ Fringe benefits (check this box if the plan provides fringe benefits)

9a Plan funding arrangement (check all that apply)

- (1) ☒ Insurance
 (2) ☐ Section 412(f) insurance contracts
 (3) ☒ Trust
 (4) ☐ General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- (1) ☒ Insurance
 (2) ☐ Section 412(f) insurance contracts
 (3) ☒ Trust
 (4) ☐ General assets of the sponsor



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Form 5500 (2000)

Page 3

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10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

- (1) ☒ R (Retirement Plan Information)
(2) ☒ 1 T (Qualified Pension Plan Coverage Information)

If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year _____

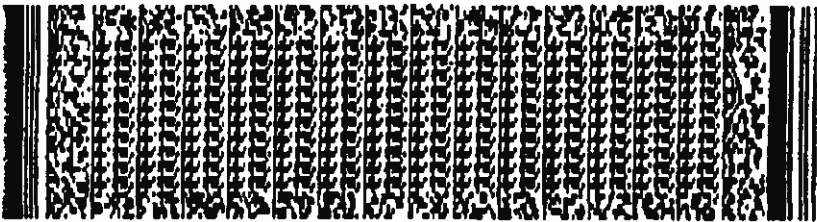
- (3) ☐ B (Actuarial Information)
(4) ☐ E (ESOP Annual Information)
(5) ☐ SSA (Separated Vested Participant Information)

b Financial Schedules

- (1) ☐ H (Financial Information)
(2) ☒ I (Financial Information -- Small Plan)
(3) ☒ 2 A (Insurance Information)
(4) ☐ C (Service Provider Information)
(5) ☐ D (DFE/Participating Plan Information)
(6) ☐ G (Financial Transaction Schedules)
(7) ☒ 1 P (Trust Fiduciary Information)

c Fringe Benefit Schedule

- ☐ F (Fringe Benefit Plan Annual Information)



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Mark A. Crimbo, M.D.
11 Chestnut Road
Livingston, N.J. 07039-1793



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FWBA
P.O. BOX 7049
LAWRENCE, KANSAS 66044-7049

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American Pension Corporation

1375 PLAINFIELD AVENUE • WATCHUNG, NEW JERSEY 07069
(908) 757-5151 • Facsimile (908) 757-9644

***** ATTACHMENT TO FORM 5558 *****

The attached form 5558 was timely filed by American Pension Corporation prior to July 31, 2001. Unfortunately a number of 5558 forms were inadvertently mailed to the DOL where the 5500 forms are processed rather than to the IRS. This was an honest mistake and it is understandable how this snafu occurred.

The error in the mailing address was discovered on July 27, 2001 just prior to the filing deadline. We promptly filed signed copies of all of the extensions with the Internal Revenue Service.

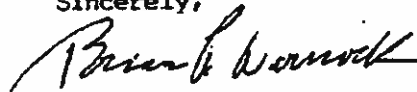
Apparently the DOL forwarded a large batch of the 5558's to the IRS well after the July 31st deadline. Although it would have been nice had the IRS considered the forms to have been timely filed, they apparently used the date that they received the forms from the Department of Labor rather than the actual mailing date. As a result, the IRS mailed out letters denying several extensions.

To sum up, while the original filing of the extension may have been denied by the IRS, a second filing was made prior to July 31st. Since the IRS no longer acknowledges timely filed extensions, the purpose of this letter is to advise you that an extension was timely filed and is, therefore, automatically approved.

Kindly mark your records to indicate that a valid extension was timely filed extending the deadline to October 15, 2001. Please do not assess any penalty charges as there obviously was a reasonable cause for any delay in the IRS receiving the original 5558. Again, whether or not the IRS received the original filing from the DOL by July 31st, a second filing was made prior to July 31st.

Please contact our office should you have any questions. Your cooperation in this matter is greatly appreciated.

Sincerely,



Brian P. Warnock
Vice President

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337.06.0020
03

American Pension Corporation

1375 PLAINFIELD AVENUE • WATCHUNG, NEW JERSEY 07069
(908) 757-5151 • Facsimile (908) 757-9644

SEPTEMBER 11, 2001 TERRORIST ATTACK

TO: DEPARTMENT OF LABOR

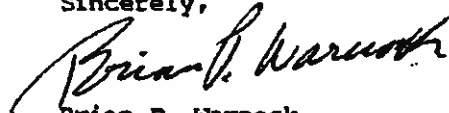
RE: NOTICE 2001-61 and
NOTICE 2001-63
TERRORIST ATTACK

American Pension Corporation, the third party administrator that prepared the attached 5500 form, is located in New Jersey, approximately 25 miles away from New York City. All of our employees have friends, neighbors, and family members who were affected, directly or indirectly, by the terrorist attack on the World Trade Center.

The attack resulted in a loss of work hours as well as a temporary disruption of our phone, fax, and mail service. There was also a general loss of productivity in our office, as we dealt with the shock of the day's events. Lately, even the simple act of opening the day's mail has been slowed down as we hear daily reports of Anthrax being sent through the mail. As a result, despite our best efforts, we were unable to complete the 5500 forms prior to the filing deadline.

We, therefore, request that any penalties for late filing be abated. Your cooperation and understanding in this matter is greatly appreciated.

Sincerely,



Brian P. Warnock
Vice President

Form **5558**
(Rev. May 2000)

Application for Extension of Time To File Certain Employee Plan Returns

Department of the Treasury
Internal Revenue Service

► For Paperwork Reduction Act Notice, see instructions on back.

8403721982
OMB No. 1545-0047

File With IRS Only

File before the
normal due
date of the
Form 5500,
5500-EZ, or
5330 (see
instructions)

Name of filer, plan administrator, or plan sponsor (see instructions)

Diagnostic & Clinical Cardiology PA

Number, street, and room or suite no. (If a P.O. box, see instructions.)

11 Chadwick Road

City or town, state, and ZIP code

Livingston, NJ 07039

Filer's Identifying Number—Check applicable box and enter number (see instructions).

☒ Employer identification number (EIN). Filers checking box 1a must enter an EIN. All other filers, see specific instructions.

22-2323990

OR

☐ Social security number (see Specific Instructions)

1 I request an extension of time until 10 / 15 / 01 to file (check appropriate box(es)).
month day year

a ☒ Form 5500 or 5500-EZ (no more than 2½ months).

The application IS automatically approved to the date shown on line 1 (above) if: (1) box 1a is checked, (2) the Form 5558 is signed and filed on or before the normal due date of Form 5500 or 5500-EZ for which this extension is requested, and (3) the date on line 1 is no more than 2½ months after the normal due date.

You must attach a copy of this Form 5558 to each Form 5500 and 5500-EZ filed after the due date for the plans listed below.

b ☐ Form 5330 (no more than 6 months). Payment amount attached is \$ _____ (see instructions)

2 Complete the following for the plan(s) covered by this application (see How To File):

Plan name/filer	Type of plan (check)			Plan number	Plan year ending		
	Pension	Welfare	Fringe		Month	Day	Year
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.	X			0001	12	31	00
MONEY PURCHASE PLAN							

3 State in detail why you need the extension (if line 1b is checked)

Under penalties of perjury, I declare that to the best of my knowledge and belief the statements made on this form are true, correct, and complete, and that I am authorized to prepare this application.

Signature ►

John M. Chaplik

Date ► JUL 18 2001

Notice to
Applicant

To Be Completed by the IRS if line 1b is checked ▼

☐ This application for extension to file Form 5330 IS approved to the date shown on line 1, if line 1b is checked. (You MUST attach an approved copy of this form to each Form 5330 that was granted an extension.)

☐ The date entered on line 1 is more than the 6-month maximum time allowed for Form 5330. This application is approved to _____ (You MUST attach an approved copy of this form to each Form 5330 that was granted an extension.)

☐ The application for an extension for Form 5330 IS NOT approved, because it was filed after the normal due date of the return. (A 10-day grace period IS NOT granted.)

☐ This application for an extension for Form 5330 IS NOT approved, because

☐ The application was not signed.

☐ No reason was given on this application or the reason was not acceptable.

☐ No payment was attached for the tax due on Form 5330.

☐ Other ►

A 10-day grace period is granted from the date shown below or the due date of the return, whichever is later. (You MUST attach a copy of this form to each return you file that is granted a grace period.)

(Date)

(Director)

By: _____

Applicants for extension of Form 5330: Complete if you want this Form 5558 returned to an address other than the address shown above.

Please
Print
or
Type

Name

Number, street, and room or suite no. (If a P.O. box, see instructions.)

City or town, state, and ZIP code

MGA

Form 5558 (Rev. 5-2000)

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SCHEDULE A
(Form 5500)
Department of the Treasury
Internal Revenue Service
Department of Labor
Pension and Welfare Benefits Administration
Pension Benefits Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

► File as an attachment to Form 5500.

► Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

2000

This Form is Open to Public Inspection

For the calendar year 2000 or fiscal plan year beginning _____ and ending _____

A Name of plan DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN	B Three-digit plan number 002
C Plan sponsor's name as shown on line 2a of Form 5500 DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.	D Employer Identification Number 22-2323990

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions.

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage:

(a) Name of insurance carrier

NEW YORK LIFE

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
		P8102530	1	01/01/2000	12/31/2000

2 Insurance fees and commissions paid to agents, brokers, and other persons:

Totals	
Amount of commissions paid	Fees paid / Amount
0	0

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. v3.2 Schedule A (Form 5500) 2000



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Schedule A (Form 5500) 2008

Page 2

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(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

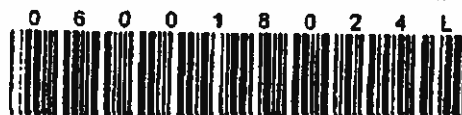
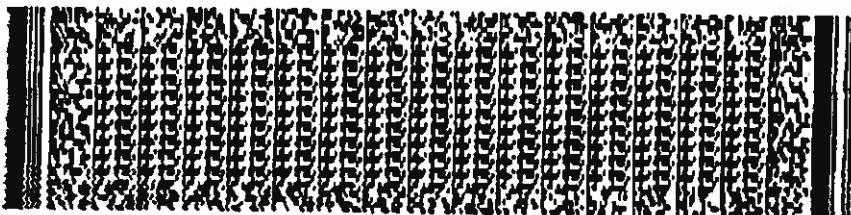
(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	



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Schedule A (Form 5500) 2000

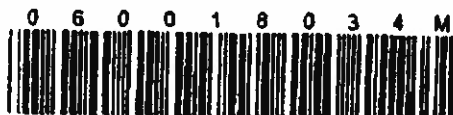
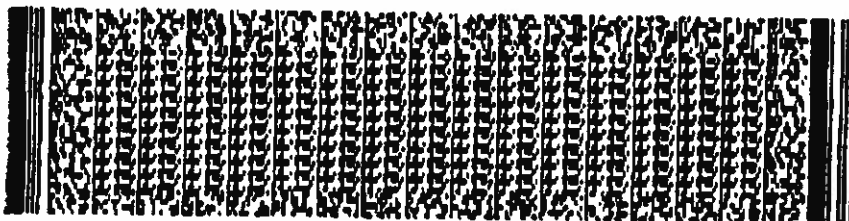
Page 3

Official Use Only

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

3 Current value of plan's interest under this contract in the general account at year end		
4 Current value of plan's interest under this contract in separate accounts at year end		
5 Contracts With Allocated Funds		
a State the basis of premium rates ON FILE WITH THE DEPT. OF INS.		
b Premiums paid to carrier		42000
c Premiums due but unpaid at the end of the year		
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount		
Specify nature of costs N/A		
e Type of contract (1) <input checked="" type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity		
(3) <input type="checkbox"/> other (specify) _____		
f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here <input type="checkbox"/>		
6 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)		
a Type of contract (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee		
(3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other (specify below) _____		
b Balance at the end of the previous year		
c Additions: (1) Contributions deposited during the year		
(2) Dividends and credits		
(3) Interest credited during the year		
(4) Transferred from separate account		
(5) Other (specify below)		
(6) Total additions		
d Total of balance and additions (add b and c (5)).		
e Deductions:		
(1) Disbursed from fund to pay benefits or purchase annuities during year		
(2) Administration charge made by carrier		
(3) Transferred to separate account		
(4) Other (specify below)		
(5) Total deductions		
f Balance at the end of the current year (subtract e(5) from d)		



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Schedule A (Form 5500) 2000

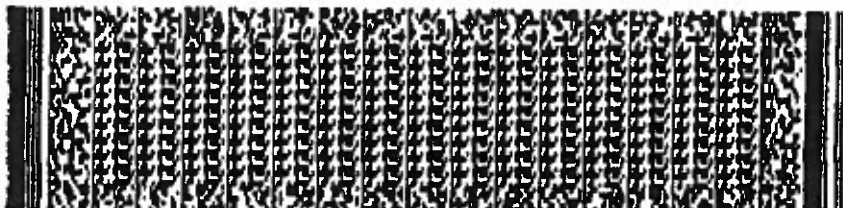
Page 4

Official Use Only

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes on this report.

7 Benefit and contract type (check all applicable boxes)			
<input type="checkbox"/> a Health (other than dental or vision)	<input type="checkbox"/> b Dental	<input type="checkbox"/> c Vision	<input type="checkbox"/> d Life insurance
<input type="checkbox"/> e Temporary disability (accident and sickness)	<input type="checkbox"/> f Long-term disability	<input type="checkbox"/> g Supplemental unemployment	<input type="checkbox"/> h Prescription drug
<input type="checkbox"/> i Stop loss (large deductible)	<input type="checkbox"/> j HMO contract	<input type="checkbox"/> k PPO contract	<input type="checkbox"/> l Indemnity contract
<input type="checkbox"/> m Other (specify) _____			
8 Experience-rated contracts			
a Premiums: (1) Amount received			
(2) Increase (decrease) in amount due but unpaid			
(3) Increase (decrease) in unearned premium reserve			
(4) Earned ((1) + (2) - (3))			
b Benefit charges: (1) Claims paid			
(2) Increase (decrease) in claim reserves			
(3) Incurred claims (add (1) and (2))			
(4) Claims charged			
c Remainder of premium: (1) Retention charges (on an accrual basis) -			
(A) Commissions			
(B) Administrative service or other fees			
(C) Other specific acquisition costs			
(D) Other expenses			
(E) Taxes			
(F) Charges for risks or other contingencies			
(G) Other retention charges			
(H) Total retention			
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)			
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			
(2) Claim reserves			
(3) Other reserves			
e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)			
9 Nonexperience-rated contracts:			
a Total premium or subscription charges paid to carrier			
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount			
Specify nature of costs _____			



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SCHEDULE A
(Form 5500)
Department of the Treasury
Internal Revenue Service
Department of Labor
Pension and Welfare Benefits Administration
Pension Benefits Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

File as an attachment to Form 5500.

Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1510-0110

2000

This Form is Open to Public Inspection

For the calendar year 2000 or fiscal plan year beginning and ending

A Name of plan DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN	B Three-digit plan number 002
C Plan sponsor's name as shown on line 2a of Form 5500 DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.	D Employer Identification Number 22-2323990

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions.

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage:

(a) Name of insurance carrier

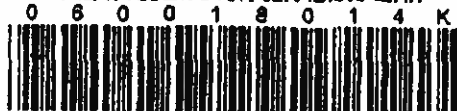
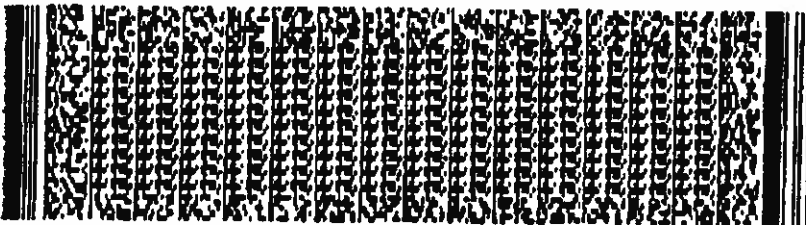
PROVIDENT MUTUAL

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
		4024790	1	01/01/2000	12/31/2000

2 Insurance fees and commissions paid to agents, brokers, and other persons:

Totals	
Amount of commissions paid	Fees paid / Amount
0	0

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. v3.2 Schedule A (Form 5500) 2000



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Schedule A (Form 5500) 2000

Page 2

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(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

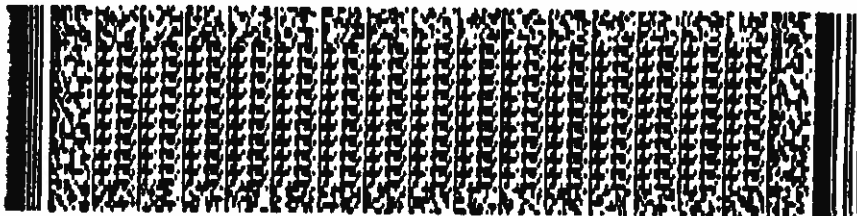
(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	



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Schedule A (Form 5500) 2000

Page 3

Official Use Only

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

3 Current value of plan's interest under this contract in the general account at year end		
4 Current value of plan's interest under this contract in separate accounts at year end		
5 Contracts With Allocated Funds		
a State the basis of premium rates ON FILE WITH THE DEPT. OF INS.		
b Premiums paid to carrier		0
c Premiums due but unpaid at the end of the year		
d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount		
Specify nature of costs N/A		
e Type of contract (1) <input checked="" type="checkbox"/> individual policies (2) <input type="checkbox"/> group deferred annuity		
(3) <input type="checkbox"/> other (specify)		
f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here		<input type="checkbox"/>
6 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)		
a Type of contract (1) <input type="checkbox"/> deposit administration (2) <input type="checkbox"/> immediate participation guarantee		
(3) <input type="checkbox"/> guaranteed investment (4) <input type="checkbox"/> other (specify below)		
b Balance at the end of the previous year		
c Additions: (1) Contributions deposited during the year		
(2) Dividends and credits		
(3) Interest credited during the year		
(4) Transferred from separate account		
(5) Other (specify below)		
(6) Total additions		
d Total of balance and additions (add b and c (6))		
e Deductions:		
(1) Disbursed from fund to pay benefits or purchase annuities during year		
(2) Administration charge made by carrier		
(3) Transferred to separate account		
(4) Other (specify below)		
(5) Total deductions		
f Balance at the end of the current year (subtract e(5) from d)		



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Schedule A (Form 6500) 2000

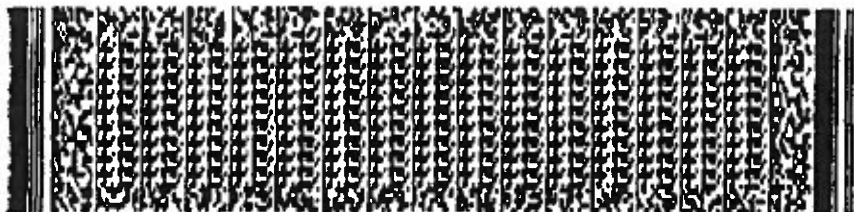
Page 4

Official Use Only

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes on this report.

7. Benefit and contract type (check all applicable boxes)			
<input type="checkbox"/> a Health (other than dental or vision)	<input type="checkbox"/> b Dental	<input type="checkbox"/> c Vision	<input type="checkbox"/> d Life insurance
<input type="checkbox"/> e Temporary disability (accident and sickness)	<input type="checkbox"/> f Long-term disability	<input type="checkbox"/> g Supplemental unemployment	<input type="checkbox"/> h Prescription drug
<input type="checkbox"/> i Stop loss (large deductible)	<input type="checkbox"/> j HMO contract	<input type="checkbox"/> k PPO contract	<input type="checkbox"/> l Indemnity contract
<input type="checkbox"/> (m) Other (specify) _____			
8. Experience-rated contracts			
a. Premiums: (1) Amount received			
(2) Increase (decrease) in amount due but unpaid			
(3) Increase (decrease) in unearned premium reserve			
(4) Earned ((1) + (2) - (3))			
b. Benefit charges: (1) Claims paid			
(2) Increase (decrease) in claim reserves			
(3) Incurred claims (add (1) and (2))			
(4) Claims charged			
c. Remainder of premium: (1) Retention charges (on an accrual basis) --			
(A) Commissions			
(B) Administrative service or other fees			
(C) Other specific acquisition costs			
(D) Other expenses			
(E) Taxes			
(F) Charges for risks or other contingencies			
(G) Other retention charges			
(H) Total retention			
(2) Dividends or retroactive rate refunds. (These amounts were <input type="checkbox"/> paid in cash, or <input type="checkbox"/> credited.)			
d. Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			
(2) Claim reserves			
(3) Other reserves			
e. Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)			
9. Nonexperience-rated contracts:			
a. Total premiums or subscription charges paid to carrier			
b. If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount			
Specify nature of costs _____			



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**SCHEDULE I
(Form 5500)**Department of the Treasury
Internal Revenue ServiceDepartment of Labor
Pension and Welfare Benefits
Administration

Pension Benefit Guaranty Corporation

Financial Information -- Small Plan

This schedule is required to be filed under Section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).

File as an attachment to Form 5500.

Official Use Only

OMB No. 1510-0110

2000This Form Is Open
to Public Inspection.

For calendar year 2000 or fiscal plan year beginning

and ending

A Name of plan

DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN

**B Three-digit
plan number**

002

C Plan sponsor's name as shown on line 2a of Form 5500

DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.

D Employer Identification Number

22-2323990

Complete Schedule I if the plan covered fewer than 100 participants as of the beginning of the plan year. You may also complete Schedule I if you are filing as a small plan under the 80-120 participant rule (see instructions). Complete Schedule H if reporting as a large plan or DFE.

Part I Small Plan Financial Information

Report below the current value of assets and liabilities, income, expenses, transfers and changes in net assets during the plan year. Combine the value of plan assets held in more than one trust. Do not enter the value of the portion of an insurance contract that guarantees during this plan year to pay a specific dollar benefit at a future date. Include all income and expenses of the plan including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar.

1 Plan Assets and Liabilities:		(a) Beginning of Year	(b) End of Year
a Total plan assets	1a	8,194,766	10,344,625
b Total plan liabilities	1b		
c Net plan assets (subtract line 1b from line 1a)	1c	8,194,766	10,344,625
2 Income, Expenses, and Transfers for this Plan Year:		(a) Amount	(b) Total
a Contributions received or receivable			
(1) Employers	2a(1)	364952	
(2) Participants	2a(2)		
(3) Others (including rollovers)	2a(3)		
b Noncash contributions	2b		
c Other income	2c	2,065,289	
d Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	2d		2,430,241
e Benefits paid (including direct rollovers)	2e	238382	
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Other expenses	2h	42000	
i Total expenses (add lines 2e, 2f, 2g, and 2h)	2i		280382
j Net income (loss) (subtract line 2i from line 2d)	2j		2,149,859
k Transfers to (from) the plan (see instructions)	2k		

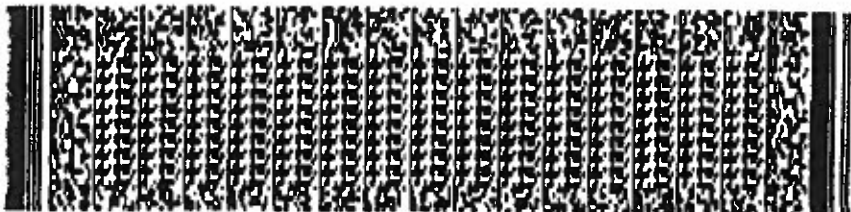
3 Specific Assets: If the plan held assets at anytime during the plan year in any of the following categories, check "Yes" and enter the current value of any assets remaining in the plan as of the end of the plan year. Allocate the value of the plan's interest in a commingled trust containing the assets of more than one plan on a line-by-line basis unless the trust meets one of the specific exceptions described in the instructions.

	Yes	No	Amount
a Partnership/joint venture interests	3a	X	
b Employer real property	3b	X	

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

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Schedule I (Form 5500) 2000



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Schedule I (Form 5500) 2008

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	Yes	No	Amount
3c Real estate (other than employer real property)		X	
d Employer securities		X	
e Participant loans		X	
f Loans (other than to participants)		X	
g Tangible personal property		X	

Part II Transactions During Plan Year

	Yes	No	Amount
4 During the plan year:			
a Did the employer fail to transmit to the plan any participant contributions within the maximum time period described in 29 CFR 2510.3-102? (See instructions)		X	
b Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by the participants' account balance		X	
c Were any leases to which the plan was a party in default or classified during the year as uncollectible?		X	
d Did the plan engage in any nonexempt transaction with any party-in-interest?		X	
e Was the plan covered by a fidelity bond?	X		350000
f Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
g Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
h Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
i Did the plan at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest?		X	
j Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	

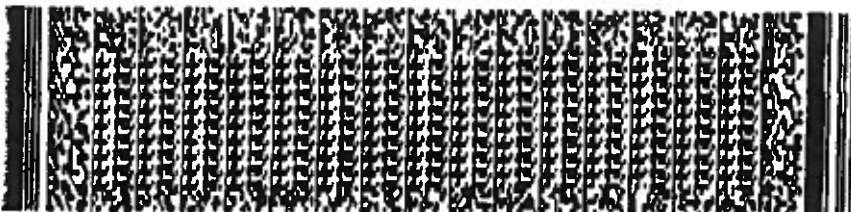
5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? If yes, enter the amount of any plan assets that reverted to the employer this year ☐ Yes ☒ No Amount _____

5b If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)

5b(2) EIN(s)

5b(3) PN(s)



**SCHEDULE P
(FORM 5500)**

Department of the Treasury
Internal Revenue Service

**Annual Return of Fiduciary
of Employee Benefit Trust**

This schedule may be filed to satisfy the requirements under section 6033(a) for an annual information return from every section 401(a) organization exempt from tax under section 501(a).

Filing this form will start the running of the statute of limitations under section 6501(a) for any trust described in section 401(a) that is exempt from tax under section 501(a).

► File as an attachment to Form 5500 or 5500-EZ.

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Official Use Only

OMB No. 1510-0110

2000

This Form is Open to
Public Inspection.

For trust calendar year 2000 or fiscal year beginning

and ending

1a Name of trustee or custodian

MARIO CRISCITO, M.D.

b Number, street, and room or suite no. (If a P.O. box, see the instructions for Form 5500 or 5500-EZ.)

769 NORTFIELD AVENUE

c City or town, state, and ZIP code

WEST ORANGE

NJ 07052

2a Name of trust

DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN

b Trust's employee identification number 22-2323990

3 Name of plan if different from name of trust

4 Have you furnished the participating employee benefit plan(s) with the trust financial information required to be reported by the plan(s)?

☒ Yes ☐ No

5 Enter the plan sponsor's employer identification number as shown on Form 5500 or 5500-EZ.

22-2323990

Under penalties of perjury, I declare that I have examined this schedule, and to the best of my knowledge and belief it is true, correct, and complete.

Signature of fiduciary

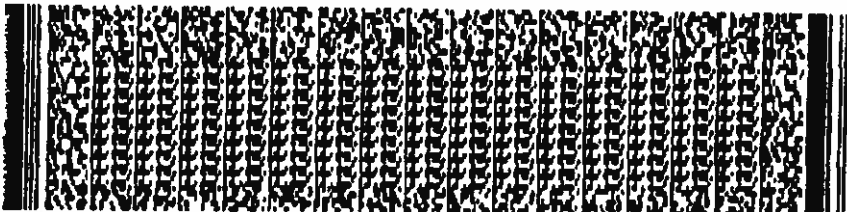
Date

10/21/01

For the Paperwork Reduction Notice and OMB Control Numbers, see the instructions for Form 5500 or 5500-EZ.

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Schedule P (Form 5500) 2000



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SCHEDULE T
(Form 5500)

Department of the Treasury
Internal Revenue Service

Qualified Pension Plan Coverage Information

This form is required to be filed under section 6058(a) of the
Internal Revenue Code (the Code).

▶ File as an attachment to Form 5500.

Official Use Only

OMB No. 1510-0110

2000

This Form is Open to
Public Inspection.

For calendar year 2000 or fiscal plan year beginning

and ending

A Name of plan

DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN

B Three-digit
plan number ▶

002

C Plan sponsor's name as shown on line 2a of Form 5500

DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.

D Employer identification Number
22-2323990

Note: If the plan is maintained by:

More than one employer and benefits employees who are not collectively-bargained employees, a separate Schedule T may be required for each employer (see the instruction for line 1).

An employer that operates qualified separate lines of business (QSLOBs) under Code section 414(r), a separate Schedule T may be required for each QSLOB (see the instruction for line 2).

- 1 If this schedule is being filed to provide coverage information regarding the noncollectively bargained employees of an employer participating in a plan maintained by more than one employer, enter the name and EIN of the participating employer:

1a Name of participating employer

1b Employer identification number

- 2 If the employer maintaining the plan operates QSLOBs, enter the following information:

a The number of QSLOBs that the employer operates is

b The number of such QSLOBs that have employees benefiting under this plan is

c Does the employer apply the minimum coverage requirements to this plan on an employer-wide rather than a QSLOB basis? ☐ Yes ☐ No

d If the entry on line 2b is two or more and line 2c is "No," identify the QSLOB to which the coverage information given on line 3 or 4 relates.
▶

- 3 Exceptions - Check the box before each statement that describes the plan or the employer. Also see instructions.
If you check any box, do not complete the rest of this Schedule.

a ☐ The employer employs only highly compensated employees (HCEs).

b ☐ No HCEs benefited under the plan at anytime during the plan year.

c ☐ The plan benefits only collectively-bargained employees.

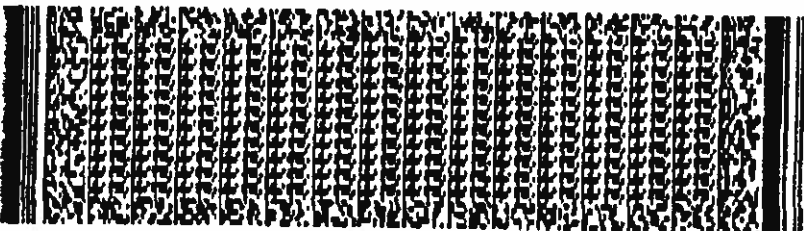
d ☐ The plan benefits all nonexcludable nonhighly compensated employees of the employer (as defined in Code sections 414(b), (c), and (m)), including leased employees and self-employed individuals.

e ☐ The plan is treated as satisfying the minimum coverage requirements under Code section 410(b)(6)(C).

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

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Schedule T (Form 5500) 2000



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Schedule T (Form 5500) 2000

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4 Enter the date the plan year began for which coverage data is being submitted. Month 01 Day 01 Year 2000

3 Did any leased employees perform services for the employer at any time during the plan year? ☐ Yes ☒ No

b In testing whether the plan satisfies the coverage and nondiscrimination tests of Code sections 410(b) and 401(a)(4), does the employer aggregate plans? ☐ Yes ☒ No

c Complete the following:

(1) Total number of employees of the employer (as defined in Code section 414(b), (c), and (m)), including leased employees and self-employed individuals	c(1)	17
(2) Number of excludable employees as defined in IRS regulations (see instructions)	c(2)	0
(3) Number of nonexcludable employees. (Subtract line 4c(2) from line 4c(1))	c(3)	17
(4) Number of nonexcludable employees (line 4c(3)) who are HCEs	c(4)	4
(5) Number of nonexcludable employees (line 4c(3)) who benefit under the plan	c(5)	16
(6) Number of benefiting nonexcludable employees (line 4c(5)) who are HCEs	c(6)	4

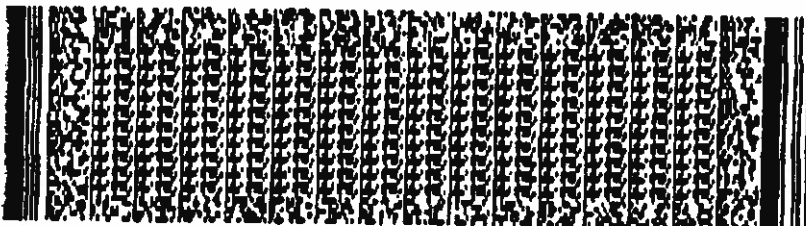
d Enter the plan's ratio percentage and, if applicable, identify the disaggregated part of the plan to which the information on lines 4c and 4d pertains (see instructions)

d	92.3	%
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e Identify any disaggregated part of the plan and enter the ratio percentage or exception (see instructions)

(1) Disaggregated part:	Ratio % or Exception:	e(1)	%
(2) Disaggregated part:	Ratio % or Exception:	e(2)	%
(3) Disaggregated part:	Ratio % or Exception:	e(3)	%

f This plan satisfies the coverage requirements on the basis of (check one): ☒ the ratio percentage test ☐ average benefit test



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